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ABSTRACT

Written from a criminal justice perspective, the report on child abuse intervention provides a model system that emphasizes prompt medical treatment for the child and due process for both parents and children. The authors recommend that court action take the form of a civil proceeding whenever possible. Part I provides a framework for the prescriptive package on child abuse intervention with chapters on what is known about child abuse; the strategy of the model system (including a review of the literature and an overview of problems in child welfare and the civil and criminal law process); the strategy of the model system (including the definition of child abuse, a hypothetical case study in the model system, and mandatory vs. permissive reporting); and model system development (including the "gatekeeper" and "guardianship" concepts and education and training for system development). Part 2, on the operation of the model system, has chapters on the following topics: the emergency intake, examination, and service process; the law enforcement role in handling suspected child abuse; the civil adjudication strategy and process; and accountability and performance monitoring. The final section is a framework and guide for child abuse decision making and includes a detailed comparison of existing and proposed model systems for handling child abuse intervention, a model decision making guide, and questions and answers on handling child abuse for justice system personnel. (DB)

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PRESCRIPTIVE PACKAGE

CHILD ABUSE INTERVENTION

BY

ARNOLD SCHUCHTER

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FOREWORD

Child abuse is now widely recognized as a problem of major proportions, one that cuts across all social levels. Much has been written in recent years about the battered child, but the role of the criminal justice system in dealing with the problem has been only marginally explored.

Child Abuse Intervention is the first report on the subject written from the criminal justice perspective. It offers a model system that emphasizes prompt medical treatment for the child and due process for both parents and children. For the most part, its many recommendations can be easily implemented in existing agencies without significantly increased expenditures or additional personnel.

Under the system proposed, the police would intervene in suspected child abuse cases and take the child immediately to a medical center for diagnosis and treatment. The medical diagnosis and evidence would be turned over to the prosecutor for a decision on how to proceed with the case. In a significant departure from existing practices, the researchers recommend that court action take the form of a civil proceeding whenever possible. In many cases, the researchers found, the traditional adversary proceeding is unnecessarily punitive and fails to change the behavior of abusive parents. Moreover, judges often must make immensely difficult decisions on the basis of sketchy or subjective evidence, with very few resources and alternatives available. A civil proceeding, the researchers conclude, would ensure due process for parents and children in an atmosphere more conducive to finding solutions that protect the child and help the family cope with its problems.

Gerald M. Caplan,
Director

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We'd like to know what you think of this Prescriptive Package.

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Will you take a few moments to complete it? The postage is prepaid.

Your answers will help us provide you with more useful Prescriptive Packages.

ACKNOWLEDGMENTS

The authors are grateful to the people who provided advice and detailed criticism in the preparation of the Prescriptive Package. We are particularly indebted to the following individuals:

Hunter Hurst, Director, National Center for Juvenile Justice, University of Pittsburgh; The Honorable James Lincoln, Wayne County Juvenile Court; Linda Lipton, Children's Defense Fund; Dr. Eli H. Newberger, Director, Family Development Study, Children's Hospital Medical Center; and

Robert Aserkoff, Model Program Development Division, Office of Technology Transfer, National Institute of Law Enforcement and Criminal Justice.

It should be clear that none of the persons who influenced the development and redrafting of the manuscript, nor the organizations with which they are affiliated, endorse the conceptual or operational components of this volume. In fact, some of them strongly disagree with a number of the basic concepts while others may disagree with important details. This was inevitable to begin with, and intentional on our part, however, since we sought out persons to review the volume who would bring different perspectives, strong opinions, and professional expertise developed from experience in different geographic areas and institutional settings.

We are also indebted to the following persons for their helpful comments and criticisms of drafts of the Prescriptive Package:

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A particular debt of gratitude is owed to Dennis Flanagan without whose consultation and competent assistance the legal components of this volume could not have been drafted.

NOTE TO READER

The Appendixes to this Prescriptive Package - *Child Abuse Intervention* are available as a loan document from the National Criminal Justice Reference Service (NCJRS), P.O. Box 24036, S.W. Post Office, Washington, D.C. 20024, *through* your organization library or local public library.

To obtain a loan copy of the Appendixes, contact your library which will process your request through the Inter-Library Loan Service. In requesting a loan copy, please furnish the library with the title, *Child Abuse Intervention Appendixes*, and the full name and address of NCJRS.

INTRODUCTION: USER'S GUIDE TO THEMES AND ORGANIZATION

The concept of a "model system," applied to child abuse or any other social problem, can be extremely misleading. The concept suggests that its designers are furnishing an interlocking set of conclusions about policy and operational choices. In this perspective, a "model system" amounts to nothing more than an overly simplistic set of doctrines, whereas the authors of this volume have earnestly tried to avoid a doctrinaire approach. Rather, we view the proposed "model system" as a technique of planning and thinking about an extremely complex human problem area which is intertwined with a multiplicity of human needs, problems and events. At the same time, we have sought to avoid a romantic point of view that fails to recognize the scarcity of resources, in child abuse and other human need areas, relative to the potential demands on these resources.

In the process of reducing the confusion and diversity of the real world to manageable terms, almost inevitably we risk entrapment in some form of Garden of Eden in which a "model system" fosters the illusion that no scarcities and confounding confusions exist. This type of romantic "model system" would be a poor guide to social policy choices regarding child abuse in the 1970's and years to come. This Prescriptive Package approaches the problems of child abuse from the point of view of the policy maker—legislative, executive, and judicial—as well as the professional practitioner, within and outside the justice system, faced with the continuing dilemmas of difficult choices that have to be made in the face of scarce resources: dollars, skilled manpower, quantity and quality of services, organization of service delivery, and so forth.

Even if a "model system" could be designed to eliminate all of the imperfections in current resource utilization, child advocates focusing on child abuse problems would still be competing with a multitude of other powerful demands for our society's resources. Their case that "the healthy development of children should be the most important goal of society" would still fail to convince most people who persist in placing a higher value on satisfying other wants. Thus, the proposed "model system" relies mainly on existing resources in child abuse intervention being put to alternative uses, to begin with on an experimental basis to prove the worthwhileness of the reallocation of scarce resources to an increasingly broad audience of policy makers and practitioners.

A number of central themes run through this volume. The first theme is that the connection between what we know from available research and experience is not nearly as directly relevant to practice as most discussions of child abuse problems and intervention strategies would have us believe. Probably this observation is no great surprise to most readers in any human service or justice system field because it characterizes the relationships between theory, research and practice in all of these fields. But the point still needs to be developed and underscored in order to set the stage for a more openminded and minimally doctrinaire discussion of a strategy alternative to the existing patterns of child abuse intervention.

Chapter I of Part 1 develops the themes of, on the one hand, the sponginess of what we currently know about all aspects of child abuse and, on the other hand, the kinds of practical problems in child abuse intervention that urgently need to be addressed by applied research and systematic institutional and program monitoring and analysis. These themes are further developed in Chapter II of Part 1 which discusses current trends in the (re)definition of child abuse which the authors feel seek to broaden the grounds for state intervention without adequate research to support this extension.

As with most of the problems of human need and justice affecting children or adults, it is the institutional configuration of services, the legal framework for public intervention, and the nature of professional roles, rather than the actual needs of clients or patients, which have the major influence on the remedial options provided by society.

The consumer of services in actuality has very little influence over the choices for care or rehabilitation. Child abuse is no different, as we see in Part I and all subsequent Parts. The strategy for the "model system" doesn't attempt to change this situation except insofar as it seeks to conceptually, legally and institutionally limit or constrain the decision-making process which in effect imposes choices on the still more or less hapless consumer, i.e., suspected abuser and abused child.

The "model system" admittedly is still authoritarian, but the key decision points where authority and power are exercised by justice system officials and helping professionals are more explicit and defined, trackable and monitorable, in terms of reasonable standards of fairness and efficacy of performance, that is, if an appropriately effective set of monitoring mechanisms are developed. Chapter II discusses our approach to legal and administrative protections for the suspected abuser and the suspected abused child in the areas of legal representation and safeguarding the confidentiality of information and the privacy of family life.

There are no villains or heros in the "model system." Depending on the professional backgrounds of readers, it will appear to some that we attribute more competence or potency to one class of professionals than others, or, on the other hand, raise more doubts about the capabilities and performance of one type of professional group than another. Other readers may feel that we slight all professionals currently dealing with child abuse or, at best, fault "the system." All of these reactions surely will find some basis in the Prescriptive Package. However, this Prescriptive Package is not a directory of villains nor a compendium of villainies. A recurring theme of this volume is that you cannot recognize the "bad guys" by their blue coats and the "good guys" by their white coats.

A recurring theme in the Parts that follow is that child abuse should be viewed as part of the "crisis" in health care in America; that the emotion-laden problem of child abuse shares with the general health care "crisis" the problem of access to primary care and emergency care; that the problem of access to primary care probably has to await broad solutions to the financing and organization of national health care, but that the problem of adequate emergency care and access to it for suspected abuse cases requires, to begin with, a change in "gatekeeping" and processing "tracks."

As we shall see in Chapters II and III of Part 1 and in Part 2, the model system proposes to invest health and medically-oriented professionals with the authority and power to bring suspected child abuse cases into diagnosis, care and protection from reinjury through a medical (and non-justice system) "track," and a carefully "guarded" one in terms of the legal rights and civil liberties of the families and injured children involved. In this regard our view of civil court process is as part of the basic institutional protections available to suspected abuse cases and their families and not simply, as viewed by many helping professionals, as a last (coercive) resort.

For different reasons, law enforcement officers and protective service workers are disqualified in the model system as primary "gatekeepers." However, each of these groups of professionals is assigned a significant role at one or another stage of the complex child abuse handling process where their legal authority and respective specializations can be most appropriately utilized. Both police and protective services are given emergency care roles of different types in terms of family crisis intervention activities. Here again, the theme of alternative uses of scarce resources is counterpointed with a theme emphasizing the emergency care aspect of child abuse intervention. Appendix IV presents a detailed analysis of the Comprehensive Emergency Services (CES) program in Nashville, Tennessee, which offers some convincing evidence of the feasibility of turning around a traditional service and legal system to be much more responsive to the needs of families involved in child abuse (and neglect) cases.

The Prescriptive Package is organized so as to facilitate use as a reference guide, a training or teaching guide, a planning guide and, not least of all, a basis for constructive discussion by an audience which, if not large, may be relatively influential at federal, state and local levels.

Most of the notes to chapters of the Prescriptive Package are drawn from the Appendix I: the Annotated Bibliography on Child Abuse. Each footnote includes a reference (e.g., AB#5) to sequentially numbered items in the Annotated Bibliography. The Annotated Bibliography is accompanied by subject, title, and author indexes. The subject index of the Annotated Bibliography is reflected in and expanded upon in the index to the Prescriptive Package as a whole in order to facilitate cross-referencing.

In addition, all of the issues and questions treated explicitly or implicitly in the Prescriptive Package are presented in Appendix II within an outline format which, in Chapter VIII of Part 3, is used to compare existing and model systems for handling child abuse. Particular attention should be paid to this outline since it provides a format which can be useful in analyzing federal or state laws and regulations pertaining to child abuse and comparing the specific and detailed provisions of these laws or regulations with those proposed in the model system.

Part 1 concentrates on presenting the "big picture" on child abuse problems and practices (Chapter I) and development of a strategy for model system development (Chapters II and III).

The strategy and content of Chapter II of Part 1 in effect is summarized in paragraph D of Chapter II which presents a hypothetical scenario of handling a suspected child abuse case in the model system. A useful technique for community planning groups, for example groups planning child abuse programs for inclusion in Title XX service plans, would be to prepare your own scenarios of how child abuse is handled in your community and compare the basic elements with the one derived from the model system. The scenario could be passed from agency to agency in the process of developing and validating its content, with participation in the drafting process from Parents Anonymous groups or others who have experienced various facets of the local child abuse handling process.

The first section of the final chapter of Part 1 develops and focuses on two of the key strategy concepts of the volume which provide the core rationale for model system development. The first is the concept of "gatekeepers": the institutions and agencies sanctioned by law with the authority and power to determine which child abuse cases are handled by the justice system, i.e., enter the "legal track," and which cases enter, and stay within, a "non-legal track," from initial report or identification through treatment. Depending on the laws governing legal jurisdiction and child abuse case handling and the initial institutional entry points, the process, experience and outcomes for the family involved in suspected child abuse can be very different.

The second basic concept is "guardianship": *systemic* and *individualized* protections for the rights and civil liberties of child and parent built into the model system for handling child abuse. These protections take the form of mechanisms for information collection and dissemination, as alternatives to central registers, and full legal representation for parents and child, together with guardian ad litem representation for the child. In other words, as child abuse cases are moving into, through and out of the domain of authority and responsibility of the primary "gatekeeper" of the model system, the operational aspects, resources and procedures of the system have to be designed to constrain our society's tendencies toward coercive overintervention.

After presenting this recapitulation of model system development concepts, paragraph B of Chapter III, Part 1, discusses ways in which education and training of justice system personnel and others involved in child abuse, including citizens at large, can serve the purpose of developing the proposed model system. Thus, education and training approaches, materials and techniques become an integral part of a strategy for model system development which should be tailored to differences in distinct geographic and problem areas within states. We stress the theme of variations in system development and program emphasis from region to region and within states in keeping with the philosophy and provisions of Title XX of the Social Security Act and, possibly, the Child Abuse Prevention and Treatment Act. The proposed model system admittedly is much more oriented to urban areas; however, based on field visits to a number of communities serving large semi-rural and rural as well as urbanized areas (see Appendix III), the model system lends itself to adaptation to particular regional and community requirements in ways that still preserve the integrity of its basic conceptual approach.

Part 2 translates the proposed strategy for the model system into the organizational components and procedures of the model system, and concludes with a discussion of monitoring the model system, or any child abuse handling system, for accountability purposes and to assess performance. If any child abuse handling system is to change for the better, it requires a thorough understanding among community agencies of why things are the way they are. Child abuse is one of the most complex human need and service areas: Even specialists in the field are hard pressed to understand its operation in detail, especially in terms of the range of issues and questions presented in Appendix II. Few simple solutions exist because few simple problems in child abuse exist. Some of the problems and issues identified in this Prescriptive Package undoubtedly defy "solution." But at least one can hope for much better operational and performance data on child abuse handling activities.

As indicated in Chapter VII of Part 2, much of this type of data is required under the planning and monitoring provisions of Title XX: data on local service needs and resources; justifications for service priorities; specific problem-solving approaches to meeting priority service needs; and evaluations of local program effectiveness. We have assumed that, in many communities, emergency and follow-up services to protect children from abuse will become one of these Title XX service priorities. Furthermore, we attempt to make a strong case for utilizing Title XX reporting and monitoring requirements and systems for assessing the performance of the state and local child abuse handling systems, rather than central registers. The case explicitly against further development of central registers is made more fully in Chapter II of Part 1, which proposes utilization of existing court data management systems, with special safeguards for confidentiality of information, as a much less costly and potentially dangerous alternative to central registers.

Part 3 concludes the Prescriptive Package with a detailed comparison of the existing and proposed model systems (Chapter VIII); a decision-making guide for the proposed model system, structured around the sequence of key decisions to be made by specified decision-makers based on recommended criteria and guidelines (Chapter IX); and a checklist of questions and answers for justice system personnel (Chapter X) keyed to the decisions outlined in Chapter IX and many of the questions and issues presented in Appendix II.

PART 1

FRAMEWORK FOR THE PRESCRIPTIVE PACKAGE ON CHILD ABUSE INTERVENTION

CHAPTER I. OVERVIEW OF WHAT IS KNOWN ABOUT CHILD ABUSE

A. Review of the Literature on Child Abuse*

1. *Introduction.* Research and other documentation on child abuse brought the problem to public awareness in the 1960's and, even more, in the Treatment Act (P.L. 93-247). Passage of this Act child abuse, many resulting in deaths and permanent injuries, strongly influenced public attitudes. The importance of child abuse among child welfare problems was recognized in the enactment, in January 1974, of the Child Abuse Prevention and Treatment Act (P.L. 93-247). Passage of this Act in a sense was the culmination of more than two decades of literature addressing the problem of the "battered" or "abused" child in this country. On the other hand, enactment of this legislation in 1974 seemed to confirm the fact that serious maltreatment of children only recently became a matter of sufficient national concern for Congressional action.

For a variety of reasons, professionals in human services and health care have been reluctant to press for increased state intervention in child abuse. Prevailing conceptions of what constitutes the limits of acceptable child discipline and punishment(1) differ in many parts of the country and have been changing over time. Likewise views as to the respective legal rights of parents and children are changing, in part as a result of Supreme Court decisions. At the same time, ambiguous and ambivalent attitudes toward children and their "best interests" contribute to reluctance to deal with child abuse problems.(2) Perhaps most of all, however, lack of confidence in what we know about the causes and dynamics of child abuse has made human service professionals and others involved in the problem cautious about advocating more aggressive intervention.

Our review of the research on child abuse and related literature confirms the wisdom of caution and restraint in dealing with this extremely complex problem. What we still don't know about the causes, characteristics and effective intervention and treatment far exceeds what we can reasonably be sure that we know.

The limited findings of only a small amount of research on child abuse, that also is very biased as to population sampled, have led us to recommend a narrow definition of the phenomenon of child abuse and a very strictly prescribed sequence of legally sanctioned diagnostic and remedial actions. The main orientation of this prescriptive package is to deter overintervention by human services and the justice system. This determination is based more on what we actually do know about the hazards of overintervention (e.g. child removal to foster care) and the lack of adequate community services resources and less on popular assumptions about prevention and treatment of child abuse.

In the 1920's, Dr. John Caffey, after studying fractures of the long bones and subdural hematoma, suggested that both types of injury, which often occurred together, might be inflicted by parents.(3) He was reluctant to publish these findings due to the pervasive skepticism of his colleagues. In 1953, Dr. F. N. Silverman reported that physical injury was the most common bone disease in children.(4) But, it wasn't until 1961, when Dr. C. Henry Kempe and his associates first proposed the "battered child syndrome,"(5) that professionals in the medical, human service and legal fields began to focus on the problem of child abuse and produce the literature reviewed in Appendix I.

The literature that followed Kempe's article on child abuse contains a considerable amount of speculation based on limited data, varied philosophies and theories or hypotheses regarding the etiology of abuse, the characteristics of abusive parents, the incidence of abused children, the dynamics of the abusing situation, and the eventual impact of child abuse on children. The sum of this research and other literature indicates that: (1) there is no definitive set of characteristics of parents (or caretakers) who abuse children; (2) there is no definitive set of factors that characterize the dynamics of households in which children are abused; (3) the available indicators of abuse, except for the physical injuries themselves, are not yet very useful for diagnosis and certainly not sufficient guidance for judges in court proceedings concerning temporary or permanent child custody; (4) prediction of the risk of (re)abuse is highly questionable, if not preposterous, based on the current state-of-the-arts in the behaviorial sciences; and (5) applying what we know about the indicators of abuse and risk of abuse, literally millions of children might have to be removed from their homes, in order to protect them from possible harm, primarily children living in poorer families who are most vulnerable to state intervention under neglect statutes.

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*See Appendix I: Annotated Bibliography on Child Abuse.

2. *Summary of the literature review.* Most authors whose writings are discussed in the annotated bibliography explicitly state that child abuse occurs among all socio-economic groups. Dr. John Caffey, for example, says that "child abusers are usually of normal intelligence, represent all races, creeds, cultural, social and educational levels, and are distributed proportionately throughout the country."(6) Unfortunately, there is no hard data to support this statement. The only systematically recorded data on the incidence of child abuse (and neglect) is maintained by state and local authorities, pursuant to reporting laws, but, for numerous reasons, this data is useless on a national scale or even in any state or locality to provide an empirical valid picture of the demographic characteristics of child abusers. Most incidence data on child abuse and abusers describes the population most vulnerable to being reported: lower income persons using public hospitals and clinics, on welfare and subject to social work contact or supervision, and without the means to use private physicians and hospitals.

The research on child abusers and abuse also mainly concentrates on this lower socio-economic group. From this small, biased sample, research has tended to draw some inordinately broad conclusions. For example, Dr. Brandt Steele, a psychiatrist, believes that all abusive parents share certain psychological characteristics to some degree: (1) immaturity and associated dependency; (2) low self esteem and a sense of incompetence; (3) reluctance to seek help related to social isolation and other factors; (4) strong belief in the value of punishment; and (5) misperceptions of the infant and the tendency to "demand a great deal from their children . . .prematurely and clearly beyond the ability of the infant . . ."(7)

Dr. Steele also asserts that abusers have had abusing parents, a view which is expressed in most of the psychiatric and social work literature.(8) According to David N. Daniels, for example, "Physical punishment by parents most likely encourages the violent behavior of children. Punishment both frustrates the child and gives him a model to imitate and learn from."(9) It should be pointed out, however, that there is no conclusive research evidence to substantiate this widely accepted hypothesis. Perhaps it's true; but perhaps it isn't. Together with the other psychological characteristics of abusers postulated by Dr. Steele and others, it may be much more hazardous for professionals involved in child abuse to unequivocally endorse them than to treat them, with appropriate caution, as a set of research hypotheses which require further research under experimental or quasi-experimental conditions.

Another such example of an intriguing but unvalidated hypothesis is found in Leontine Young's book, *Wednesday's Children,* in which she contends that, for the abusing parent, there is a perverse fascination with punishment itself, divorced from discipline and rage. For these parents, "rather it is deliberate, not impulsive; consistent, not transient; torturous in expression, not direct and instantaneous."(10)

Family situations of alleged abusers vary. Most often only one child is abused; in other families, all the children are abused. Victims are usually normal infants, but a higher incidence of abuse may be found among provocative, deformed, premature, multiple-birth, adopted, foster and step children.(11) Here again, in attempting to describe the characteristics of families in which abuse has occurred, or is alleged to have occurred, the data on which to base conclusions is limited and biased by the skewed sample.

As discussed by Stephan Cohen and Allan Sussman in *The Incidence of Child Abuse in the United States,*(12) it is currently impossible to know the actual magnitude and nature of the problem of child abuse because of: (1) lack of uniform definitions; (2) combined abuse/neglect statistics; (3) lack of uniform reporting laws which specify who is to report and to whom; (4) differing statutory ages of the children to be reported; and (5) the role of individual discretion in reporting and validating child abuse.

Although all 50 states now have reporting laws,(13) professionals are unclear as to what is reportable and to whom they should report. Many mandated reporters feel the laws are punitive rather than curative, and therefore do not report (especially private physicians). This has seemingly created an economic reporting bias, as discussed by Richard Light,(14) which tends to skew the report statistics to show most abuse occurring amongst lower socio-economic groups. As indicated previously, more affluent groups can avoid the reporting system by using private physicians and hospitals.

In most states, professionals are mandated and lay people are encouraged to report, to either one or a selection of agencies, usually including either welfare and/or law enforcement.(15) Stephan Cohen, in his *Study of Child Abuse Reporting Practices and Services in Four States*(16) touches upon many of the problems inherent in the reporting system as it exists: (1) underreporting by physicians; (2) lack of knowledge of state reporting laws and procedures on the part of mandated reporters and the general public; (3) lack of feedback to reporters; and (4) poor training and educational programs for professionals and lay people in the identification and reporting of child abuse. A primary deterrent to reporting seems to be reluctance of physicians, hospitals and human service professionals to report suspected child abuse to law enforcement officials.

The trend of recent child abuse reporting legislation has been towards broadening the types of professionals mandated to report, and also broadening the definition of reportable child abuse (via inclusion of mental abuse and neglect).(17) Conceivably this could result in an increase in cases being handled by the courts because of an already existing lack of available service alternatives to court processing.(18) As yet, however, no firm data is available on the impact of broadening the statutory definitions of abuse and increasing the types of mandated reporters. Even without such data, the trend continues in every state as part of compliance with P.L. 93-247. "The lack of congruence between the system for reporting suspected child abuse and the system for delivery of services"(19) was one of Cohen's most important findings. "The phenomena of underreporting was both a result of the inadequacy of the system and a measure of that inadequacy."(20)

We know little about the causes and dynamics of child abuse and even less about effective social intervention and treatment. Nevertheless, Congress and state legislatures apparently are committed to having more types of professionals reporting more cases of suspected abuse, fitting broader and probably biased definitions of maltreatment to wholly inadequate human services and legal systems for handling these cases. Currently, in about two-thirds of the states, information on these reported cases is supposed to be forwarded to central registries, even though the usefulness of central registries has not been established.(21) Opponents of central registries are concerned about the lack of protections for confidentiality of information. Confidentiality of the reports in such registers is mandated by Federal statute (P. L. 93-247) but the potential for excessive government intrusion into citizens' privacy remains a serious problem.(22) The trend of the recent model legislation has been towards mandating central registries in the reporting system which retain the maximum range of reports based on the slightest evidence.(23)

Once a suspected child abuse case is reported, the initial community intervention is determined by which agency is mandated to receive reports (which differs from state to state), and the availability of 24-hour protective services. An almost universal lack of 24-hour emergency protective services tends to result in overreliance on the use of law enforcement officers, and an overuse of child removal.(24) In most states, police are designated by statute as either the only, or one of several, report recipients. "Police are most frequently the agency to which reports are made."(25) When professionals have the choice of recipients, "they tend to prefer non-police agencies."(26) "In a survey of Washington, D.C. physicians, one-fourth of the respondents stated that they would not report battered children to the police, even with legal protection . . ."(27)

One solution to the police image problem has been the development of specialized units within the department (e.g., Los Angeles Child Abuse Unit).* These officers are specifically trained to handle child abuse situations. A major problem with these units is limited staff. They cannot respond to the initial report, but are called in by a patrol officer who has some suspicions about the situation. Child abuse often is a manifestation of a family crisis situation which requires special training, skill and sensitivity for police officers to respond appropriately. "In rendering police services during a family crisis situation, the very actions undertaken to reduce interpersonal conflict may precipitate or intensify violent reactions."(28)

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*See Appendix III (III-5).

Protective services in state welfare departments is another major recipient of abuse reports. It has the dual responsibility of investigating a situation and also providing services to the family. This "dual role of the child protective service caseworker—investigator versus helper—creates a stressful situation."(29)

The role of the caseworker is "key to what will happen in an abuse case. His/her decision will determine services given, removal of the child from the home, and justice system involvement."(30) Most of the literature agrees that protective services in most areas is understaffed, under-funded and "grossly under-developed . . .The lack of adequate child protective services results in an overreliance on law enforcement and courts to make decisions regarding removal of the child from the home."(31)

Hospital emergency rooms also receive many cases of abuse, either via police, schools, etc., or most often from parents themselves. Most cases of reported severe abuse are seen in hospitals. Hospitals in a number of urban centers have developed specialized diagnostic capabilities for child abuse cases. "There are enough symptomatic variables so that abuse can only be diagnosed in a hospital setting . . ."(32) One recent trend in hospital management of child abuse cases has been the multi-disciplinary team approach. "By their very nature, the problems of child abuse encompass the responsibility of many disciplines within a given community . . . . the initial phase must be considered a diagnostic medical social problem with the two disciplines closely cooperating: a coalition between the child protective services and the hospital."(33)

The development of multi-disciplinary teams reflects the conclusion of medical personnel in hospital-based child abuse programs that social investigation and other information gathering should, indeed must, be part of the medical diagnostic process. The interview with the patient is viewed as necessary to establish the circumstances of the injury and the parent's role. Excessive discipline resulting in injury of a child is one of the most common grey areas of child abuse.

Under criminal laws, parents have no more of a right to inflict injuries on their children than any other person has a right to intentionally harm a child or an adult. The right of a parent to physically discipline a child is an issue which has become the focus of much of the law and controversy pertaining to parent-child relations. "The most common standard gives the parents the right to punish a child within the bounds of moderation and reason, if done for the welfare of the child. If the parent exceeds moderation, s(he) is criminally liable. Based on the Roman legal concept of *parens patriae*, that the state has an interest in the child superior to the parents', there is an increasing tendency for the state, through the court system, to interfere with the parent-child relationship in order to protect the physical health of the child."(34)

The trend in the law and in court process seems to be moving towards increasing emphasis on protection of children's rights. "Usually law reflects the social consensus that children's best interests are synonymous with their parents' except in extreme cases . . .Little thought has been given to substantive and procedural rights of children as individuals or as a special interest group. Currently, law reform is shifting toward helping children in two ways: (1) by extending to children rights legally granted to adults; and (2) by recognizing the unique needs and interests of children, as legally enforceable rights."(35)

The legal process in child abuse cases can go through civil and/or criminal proceedings. The civil procedure is initiated by a petition, which can be filed by anyone but, in most cases, is filed by the agency either receiving the report and/or investigating the report. State intervention and the judicial decision to intrude into the family relationship or alleged abuse cases are based on a state's neglect statutes.

The inclusion of child abuse under neglect statutes perhaps is the single most problematic aspect of state intervention. In particular, the inclusion of emotional abuse and mental injury clauses in definitions of child abuse,(36) and in the reportable conditions sections of child abuse reporting laws, seems to be the trend towards which those charged with the task of formulating new legislation are moving, for example, the Model Child Protective Services Act. Many states already include, either in their neglect or abuse statutes, such terms as: mental injury; endangering morals; maltreatment; mistreatment or non-treatment;

mental and emotional welfare; debauchment or endangerment of the morals of children; impairment of emotional health. With limited public resources available for emergency services and support for families in crisis, the broader the grounds for legal intervention the more often the outcome is separation of a child from his/her home for the purpose of protecting the child from further harm.

Where physical abuse is less than serious, the actual dividing line between abuse and neglect, as statutorily defined, often may be very fine. The question raised by Fontana is, does the dividing line really matter anyway? He claims that neglect may not be abuse, but it is "maltreatment,"* which may not always be deliberate, but it is damaging.

Irrespective of the definition of injury, the family subject to civil court process essentially faces a child custody hearing. As a result of adjudication and disposition or a pre-adjudication agreement, "the child may be returned to its parent under supervision; or the social welfare agency involved may seek temporary custody, usually resulting in a foster home placement; or the agency may seek permanent custody resulting in the eventual termination of parental rights and adoption of the child."(38)

Temporary custody can be acquired either through the decision of the court, or through the parents' "voluntarily" giving up their child. "These voluntary placements are not always truly voluntary. A substantial degree of state coercion may be involved, as when state welfare departments give parents the option of giving up their children voluntarily rather than facing court process."(39) Too often children placed "temporarily" in foster care spend much of their childhood in a string of different foster homes. "Foster care, designed to be a temporary arrangement, is not typically short term."(40) ". . .children are rescued from parental neglect only to suffer public neglect, an illusion of caring."(41) A 5-year longitudinal study by Fanshel revealed that "at the end of 3.5 years, 46 percent of the study children were still in foster care."(42) A study of foster home care in Massachusetts provided the finding that "some 83 percent of the children (in temporary foster care) are never returned to their parents."(43)

Foster care often seems to fail for a variety of reasons: (1) "parents are rarely offered rehabilitation services after the children are removed—casework attention is focused on the child and the foster home; (2) long term plans that would provide children with a sense of security and stability are seldom made and rarely implemented; (3) children are moved from one foster home to another;"(44) (4) "foster care requires persons to adopt inconsistent attitudes: foster parents are expected to provide all that the natural parents would provide but they are obliged not to form any emotional attachments; and if they do, the child is often placed in another setting."(45)

"The main causes for over-reliance on foster care placement rather than family preservation include the dearth of homemaker services, day care centers, family counseling, and public education or training for child rearing and family life."(46)

Termination of parental rights is the alternative least used by the court. From the standpoint of legal issues involved, it is also one of the most complex and controversial areas of the law. The constitutionality of involuntary termination provisions, the "best interests of the child" doctrine, informality of proceedings, restrictions on the discovery and cross-examination rights of counsel, the use of "waivers" in termination proceedings, the rights of parents and child to counsel, and other issues are being challenged in appellate courts.(47) The problems connected with termination of parental rights, and the cumbersome laws and procedures connected with adoption, results in the state terminating parental rights without subsequent adoption proceedings, the hampering of cases which merit termination proceedings, or parents maintaining parental rights, with or without custody of their children, when adoption might be the best alternative.

In a civil proceeding, the state's power over the parent is through the child—essentially the threat of losing the child, temporarily or permanently. For this reason, to gain more authority and power over the parents' behavior and treatment, criminal prosecution sometimes is advocated in severe child abuse cases. The view is expressed by some criminal justice officials that some or many abusing parents must be coerced into treatment, even though no criminal charges actually are prosecuted. In other words, the threat of criminal prosecution is regarded as a necessary lever to coerce treatment.

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*"Any treatment by which a child's potential development is retarded or completely suppressed, by mental, emotional or physical suffering, is maltreatment, whether it is negative (as in deprivation of emotional or material needs) or positive (as in verbal abuse in battering.)"(37)

Actual criminal prosecution, on the other hand, probably has very little positive effect on the family situation. "...Beginning a prosecution is likely to mean the end of any possible chance to improve the child's home situation — imprisonment tears a child from the parents, fines deplete the family's resources, and reputation suffers from conviction in a criminal court."(48) Also, the penal system as it exists does not offer much in the way of rehabilitation. In any case, it is widely acknowledged by prosecutors that criminal adjudications are difficult to get because of the nature of most child abuse cases, i.e., lack of the competent witnesses and evidence to substantiate the necessary burden of proof. To date, no research data is available on the efficacy of treatment for an abusing parent under the threat of criminal prosecution or as a condition of criminal sentence. For good reasons, however, it is assumed that criminal action can prove to have negative consequences. "If the parent is acquitted, he may consider this approval of his conduct. If the parent is found guilty, he may become even more angry; his behavior won't be altered by prison."(49)

For those who view child abuse as a crime against society, there is the question of accountability. "When a child has been killed or badly injured, society cannot overlook this fact...There does not seem to be a difference between a horrible beating, or death, administered by one stranger to another, and the same act as administered by an enraged father or mother to a small child."(50)

B. Overview of Problems in the Child Welfare System

The problems which have the greatest impact upon the functioning of the entire child welfare system are: (1) the availability of trained personnel organized effectively to perform their roles and functions; (2) inadequate statutory requirements, legal processes, and lack of competent and adequately compensated legal representations; (3) lack of knowledge of what approaches are most efficient and effective; (4) lack of resources for crisis intervention and emergency services; (5) overdependence on placement in foster care; and (6) inadequate or unavailable service elements, including day care, homemaker, health, legal, counseling of various kinds, and family planning services.

Preventative efforts are grossly lacking as are protective services and treatment programs. The current national approach to child abuse and maltreatment appears to be reliance on increased reporting of individual cases of endangered children, without the assurance of a commensurate level of protective and treatment services.(51) In other words, to build the structure of state-wide reporting systems, including central registries of child protection cases, on the assumption that increased reporting will have to precede adequate funding for the upgrading of child protective and treatment resources the result will be more reporting, and more children will be saved from further injury and harm.

Child protective services are under the auspices of state public welfare, state and county public welfare, county public welfare, or state and county welfare agencies, and the county juvenile court. Irrespective of auspices and geographic coverage, the needs, gaps, problems, etc. vary mainly in degree of severity: limited funds, staff, training, facilities and resources, and so forth.(52)

Increased caseloads require more trained staff. But an equally pressing problem is figuring out how they should be trained.(53) In rural areas, for example, staff tend to be generalists who have little specific background in protective services for abused and neglected children. The improvement of child abuse handling within the existing system or in any model system has to deal with an absence of diagnostic and therapeutic preparation of caseworkers, inability to follow up with appropriate services on a timely basis, injudicious decisions due to job frustrations, lack of knowledge of the legal aspects of protective services, and so forth.(54)

More specifically, inadequate legal requirements and processes strain the ability of the child welfare system to act with legitimate authority, which results in a lack of clarity in delegating specific agency responsibility for investigations of abuse and neglect, delays in the judicial process, poor attorney and social work staff preparation in presenting cases, jurisdictional problems on Indian reservations and military bases, lack of legal representation for children and parents, and identification of neglected children as delinquent.(55)

Ideally, battered, otherwise abused, neglected, ill-treated, and deprived children should be treated as a continuum of severity of consequences for children and covered by overall child welfare programs based on a comprehensive and integrated national family policy. Therefore, it is with some reluctance that we propose to treat the phenomenon of child abuse as a discrete, specialized problem warranting a specially designed set of legislative policies and an operational system.

In the United States, in contrast to the United Kingdom, France, and Israel, we do not have universal maternal and child health programs in which all children are seen regularly from infancy on, thus facilitating identification and prevention of child abuse. The lack of a uniform and universal maternal and child health system, which functions as the case-finding system to identify children potentially at risk, leads to the necessity for special intervention initiatives. Since the danger to life and well-being may be greatest for children subjected to physical abuse, we have proposed a system which gives priority to this type of intervention. We recognize the continuing problem, resulting from singling out this category of maltreatment, of specifying and developing operational standards which delineate for practitioners the parameters of these priority cases.

The necessity for special intervention initiatives is accentuated by the inadequacies in existing child welfare programs in this country. Inadequacy of resources (money, staff, training, facilities), fragmentation of services, interdisciplinary professional and organizational conflicts and rivalries, and so forth are widely acknowledged and well-documented deficiencies in the overall non-system of specialized interventions that comprise traditional local child welfare service delivery systems. The newer approaches in child abuse and neglect, such as the Office of Child Development, Social Rehabilitation Service-funded demonstration projects, all are designed to reduce the problems by focusing on "coordinated," "multi-disciplinary," "multi-service" efforts, with "case management" and "information system" components to ensure responsibility for continuity of follow-up care to the family.

No doubt such strategies to improve and expand services for troubled families in general and abused/neglected children in particular are desperately needed and these demonstration-type efforts will make inroads on the current deficiencies in children's services. However, until the inadequacies of general child welfare programs in this country are substantially eliminated, there will be a need for concentrated concern with child abuse as a distinct problem, even at the risk that the stress on child abuse tends to divert attention away from the need for more basic social policy reforms.

Finally, the necessity for special intervention initiatives in child abuse is significantly increased by the lack of universal maternal and child health programs, integrated with school health care systems, with mandatory reporting requirements for participating doctors or specially trained nurses. Without such provisions for *all* children, child abuse will continue to be defined as a social class problem of the poor who are overexposed to public hospitals and other authorities who are more likely to report cases than private physicians. This situation leads directly to the problems of excessive social intervention in the lives of lower income families and the issues of unequal treatment of the poor under laws pertaining to abuse and neglect.

On the assumption that, for a variety of substantial reasons, private physicians are not likely to significantly increase their rate of reporting, special intervention initiatives in child abuse have to be designed to compensate, to the extent possible, for under-reporting of cases involving higher socio-economic groups and the vulnerability of lower income groups to disproportionately higher rates of reporting.

C. Overview of Problems in Operating Child Abuse Systems

The child abuse reporting, legal processing and treatment systems and activities in every state and locality are working more or less poorly. Many abusing parents are not being helped to overcome the stresses and conditions that precipitate child abuse and reabuse. In fact, we can't be certain that any of them are being helped. Despite mandatory reporting laws in most states and immunity from prosecution in all states, all states suffer from significant underreporting, especially among private physicians and school personnel.(56) Although the situation is changing rapidly, many professionals designated as reporters under state laws still probably are unaware of their legal obligation to report, and also lack knowledge of what should be reported to whom and how it should be reported.(57)

Likewise, much of the general public is unaware of its role in reporting suspected abuse and, more important, only dimly perceive child abuse as an important community problem. Where professionals and the public are aware of the requirement to report suspected abuse, for understandable reasons most do not feel competent to judge if abuse has occurred and, in any case, are ambivalent about reporting suspected incidents. In states where reporting of suspected child abuse to the police is required by law, it tends to discourage reporting and reinforce the view that the child abuse reporting and service system serves punitive purposes.(58)

Attention to child abuse in the media in this country has been focused on the sensational and outrageous end of the spectrum of the problem—beatings, burnings, scaldings, drownings, etc. Such strong and angry responses to child abuse, in the professional literature and news media, have contributed substantially to the emergence of a punitive approach to the problem.

1. *Initial intervention problems.* An important consequence of existing law and practices for initial intervention in child abuse is that, in almost all states, initial child protective responsibility is dispensed among social service agencies, police and courts. In addition to blurring accountability, these agencies have conflicting philosophies and responsibilities.(59) The primary tension in handling maltreatment of children is between law enforcement and social services.

In some communities, police handle all suspected child abuse cases as assault and battery cases under criminal statutes, even though the state law provides the option of handling these cases under child abuse and neglect statutes, using civil court procedures. In other states which require that all suspected child abuse cases be referred to law enforcement for possible criminal investigation, by informal working arrangement with police, social service handles virtually all initial investigations.(60)

The fact that community agencies often work at cross purposes, interfering with each other and duplicating functions, from initial investigation to treatment, has led to numerous proposals that, at the very least, a single agency receive and investigate all abuse (and neglect) reports in each community.(61) These proposals are made with varying degrees of understanding of the existing system for handling child abuse to which these efforts will have to be adapted and which will significantly affect the ways in which proposed new systems will function.

2. *Duality of the protective service role.* Local public social service agencies, whether state administered, state supervised or part of a local unit of government, function as the usual vehicle for handling child abuse cases. All types of cases of maltreatment come to their attention, many through their own social casework functions.

Even in communities which have active involvement of law enforcement and court personnel in the problem of child abuse, protective services units within the public welfare departments or attached to courts play a predominant role in the handling of such cases. Their functions include some or all of the following: standard setting (including the original definition of child abuse), information gathering, monitoring of parents, service delivery and follow-up. Protective service workers are in the position of either making or heavily influencing critical decisions affecting parents accused of child abuse, including the temporary removal of the children, permanent termination of parental rights and permanent removal of custody, and whether to pursue criminal prosecution.

The ambiguity or confusion of roles of protective service workers stems from their direct or indirect exercise of state powers in actions such as active monitoring of families, removal of children, and provision of advice to the court. In at least one city, protective service workers have assumed the information-gathering and surveillance functions of probation workers in cases of civil handling of child abuse.* This may interfere with the "helping relationship" normally attributed to protective service workers and would clearly interfere with development of trust based on confidentiality of information.

There are some disturbing elements to this dual role, not the least of which is the image projected to the family by protective service workers. It is unclear at what point during initial contact workers reveal to families they are "helping" that they may invoke the powers of the court to remove their children, if in their judgment that is desirable; or that throughout the "helping" process the worker is gathering evidence and witnesses that may be used in court testimony.

3. *Discriminatory and inequitable intervention.* Although there is much difference of opinion in the professional literature, many protective service workers we interviewed are reluctant to have the power to remove the child from its home or even the primary authority in child abuse cases. Their aim is to function as an agency that keeps

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*See Appendix III (III-5)

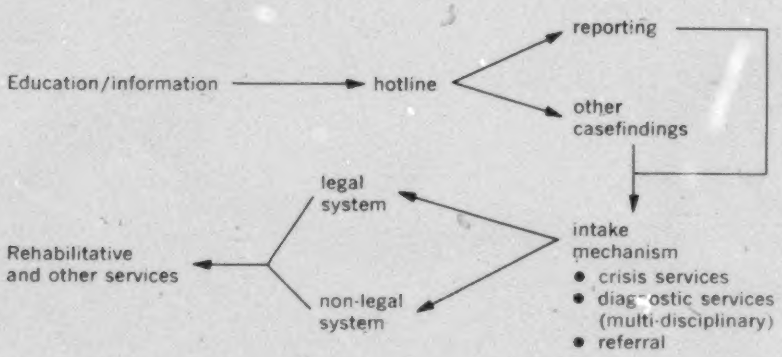
families together and they express deep ambivalence about their law enforcement and prosecutorial functions. However, these concerns extend to granting to police intervention the primary authority in child abuse cases and recognition of police competence and authority. This view in part reflects the fact that the justice system for child abuse is essentially the same as that for delinquency, which tends to discriminate against the poor in general and minorities in particular, even though child abuse is found among all economic groups and races.(62)

The specific reasons for discrimination are that: the poor use public hospitals and clinics far more than more affluent families; private physicians are least likely to report suspected cases of child abuse and personnel in public medical facilities are more likely to report suspected abuse; public welfare, mental health and protective service agencies provide supervision and surveillance of lower income families; police intrude more in the lives of lower income families; lower income urban families living in multi-family dwellings have less privacy than suburban families living in separate single-family dwellings; and the suburban middle class benefit from a presumption by their neighbors that they are fit parents. Consequently, public intervention in suspected child abuse cases is part of a pattern of vulnerability of lower income families to state surveillance and intrusion.(63)

One of the ways to correct this pattern of inequitable state intervention in child abuse would be to increase reporting by private physicians and, to a lesser extent, schools. Schools, of course, do not have contact with children younger than school age. With respect to physician reporting, among the factors which discourage reporting are the facts that the legal system (civil or, to a lesser extent, criminal) frequently is the necessary route to treatment or supportive services. These services, provided with or without legal processing, are scarce and inadequate.(64) These same factors apply equally to many potential reporters in schools as well as in hospitals and welfare agencies. Fear of involvement with the law and especially time-consuming court proceedings, with possible adverse affects on their professional reputations and relationships to clients, are additional sources of hesitancy to report suspected abuse cases, thus tending to foster underreporting of suspected cases among middle income families.(65)

Education and information programs to motivate and aid the general public and professionals to report "early suspicions" of either parental stress that may lead to child abuse or early signs of child abuse (e.g., excessively harsh discipline) is intended to increase casefinding and intake at some point in a child abuse prevention and treatment system. Often it is proposed that a 24-hour hotline be combined with the education-information program as a direct aid for parents under stress and/or as a means of facilitating abuse/neglect reports. The logic of this approach is generalized in the following flow diagram: At the end of the line of the logical flow of steps, starting with expansion of referral/self-referral/reporting, has to be expansion of the public/private service

DIAGRAM A: INTENDED OUTCOMES OF INCREASED REPORTING



resources related to the needs of clients. When the goal of the education/information/ hot-line program is to generate referrals/self-referrals/reporting covering the gamut of life-situation problems, the end of the line—rehabilitative and other services—has to be sufficient in capacity, diversity, and flexibility to absorb the potential clients and meet their needs. Otherwise the logic of planning for community intervention in child abuse (as currently defined, usually including neglect) soon leads to a breakdown of protective services.

4. *The Florida example: Inundation with child abuse reports.* Florida provides a classic illustration of the possible consequences of (1) extremely broad statutory (civil and criminal) definitions of reportable abuse/maltreatment/ neglect situations; (2) a statewide publicity campaign to generate reports to a statewide toll-free hotline; and (3) lack of manpower and resources for service follow-up. At best a great deal of data is collected about the problem; a great deal of potentially punitive activity is initiated; and probably an excessive amount of child removal results. Eventually, scarcity of manpower resources and inundation of the court system forces ad hoc priority setting focused on the most serious reported cases of abuse and neglect.

In October 1971, Florida established a centralized reporting system (WATS system) on a 24-hour, seven days a week basis. The WATS system was set up in the State Division of Family Services to open a channel through which all cases of child abuse and neglect from any source could be responded to with investigation and evaluation of the circumstances of the problem, provision of services, and/or removal of the child. The WATS system is tied into the central registry. The intent of the program was to perform intake, investigation and dispositions on all cases. Within the first 18 months, however, there were well over 31,000 children reported and, after three years, over 90,000 complaints, running at a rate of 1,500-2,000 per month. Lack of manpower has resulted in limiting investigations to the worst-sounding cases. Worker turnover is high, reflecting high caseloads and constant pressure. Still it is reported that well over 60 percent of all cases are confirmed as valid within Florida's extremely broad statutes*(66) About ten percent of cases are strictly physical abuse, which would mean that as many as 5,000-6,000 cases of physical abuse were reported and verified over the more than three-year period.

Even this seemingly high figure may grossly underestimate recent child abuse reporting rates in Florida. According to an Associated Press report,(67) between June and August 1975, verified child abuse cases treated at Dade County's Jackson Memorial Hospital almost doubled (to 87 cases) by comparison with the preceding summer, including three deaths. There were 4,000 confirmed cases of child abuse throughout Dade County in 1974 and, according to Dr. Irwin Redlener, chairman of the Hospital's Child Abuse Program Committee, the total could reach 6,000 in 1975.

A study of the abused children in Dade County reveals that the typical child abuser is a white, middle-class, college-educated woman.(68) The study attributes the abuse in part to parents who are frustrated by the lack of money in the area's slumping economy, hard-hit by cutbacks in construction. The statewide reporting system has flooded the county's protective services and hospital services with reports, but funds are lacking to expand services and treatment beyond a small fraction of the cases identified and confirmed. Thus, the child abuse reporting system apparently was "successful" in dramatically increasing the total volume of reports and also in overcoming the discriminatory tendency of under-reporting to focus disproportionately on suspected abuse cases among lower income and minority families.

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*Civil-Neglect Section:
"To assure all children. . the care, guidance and control preferably in each child's own home, which will conduce to the child's welfare and the best interests of the state;"

"dependent child" - means one:
(1) who is abandoned by his parent, or other custodian;
(2) who for any reason is destitute, homeless, dependent upon the public for support; or
(3) who has not proper parental support, maintenance care or guardianship; or
(4) who is neglected as to proper or necessary support or education as required by law, or as to medical, psychiatric, psychological or other care necessary for the well-being of the child; or
(5) whose condition or environment are such as to injure or endanger the welfare of the child or the welfare of others; or
(6) who is living in a home, by reasons of neglect, cruelty or depravity, or other adverse condition, on the part of the parent, legal custodian, guardian or other in whose care the child may be, is an unfit place for the child.

Criminal-Reporting Statute:
". . .to provide for the detection and correction of the abuse or maltreatment of children who are unable to protect themselves. Such abuse or maltreatment includes neglect, malnutrition, the infliction of severe physical injury other than by accidental means, and failure to provide necessary treatment, attention, sustenance, clothing, shelter, or medical services."

The "success" in generating reports is attributed to an extensive statewide publicity campaign involving: (1) dissemination of the WATS line number; (2) posters and billboards; (3) radio and TV spots for pre-taped publicity; (4) bumper stickers; and (5) frequent addresses to community groups. The combination of the publicity campaign and access to the WATS system produced an outpouring of reports that have swamped protective service workers, especially in metropolitan areas. The fact that the central registry is not computerized, and all cases are hand-tallied and filed, added to the workload. Worst of all, very few services and resources are available to children and their families after reports are received and verified.(69)

Florida's reporting rate under the WATS system is estimated by Saad Z. Nagi *(Child Abuse and Neglect Programs: A National overview)*(70) at about 13.4 per thousand children. Projecting this rate to the slightly more than 69 million children 17 and under in the nation would yield about 925,000 reportable cases. At a national reporting rate estimated by Nagi to be 8.8 per thousand in 1972, only 600,000 cases have been reported. Thus it could be concluded that about 325,000 abused and neglected children were not brought to the attention of protective services during 1972. As indicated above, of all the reports made in the State of Florida, about 60% were subsequently substantiated as entailing abuse and/or neglect. Therefore, *if* the nation's level of reporting and proportions substantiated are similar to those of Florida, there would be about 555,000 cases of substantiated abuse and/or neglect cases annually (at a 13.4 per thousand rate). Nagi's survey yielded an estimated average of 28 percent as the proportion of total cases reported who were considered abused, or about 18 percent higher than in Florida. Applying this proportion to Nagi's nearly 600,000 estimated reports of both abuse and neglect would yield about 167,000 cases of abuse alone; applied to 925,000 reportable cases would yield 259,000 cases of abuse.

These figures reflect much more than a statistical game of estimating the incidence of abuse. The majority of protective service workers (56%) and police (64%) in Nagi's survey "agreed" or "strongly agreed" with the statement that "it is difficult to say what is and what is not mistreatment." An even higher proportion of judges (69%) and physicians in hospitals (72%) gave similar responses. Even greater rates of agreement were voiced in reaction to the statement "it is difficult to determine when parents should have their children returned." Consequently, the more reports that fall into the middle categories of abuse and neglect, between neither abused nor neglected and clearly battered, the more decisions on case action, including child removal, involving a larger population will have to be made on very diffuse and subjective criteria.

5. *Federally funded problem-solving efforts.* A number of significant efforts are currently underway to attempt to reduce these problems by means of improved multidisciplinary coordination within community service systems, especially between specialized hospital-based diagnostic and treatment units focused on child trauma and other community agencies, and by establishing new community resources for child abuse intake and treatment. In May 1974, the Office of Child Development (OCD) and the Social and Rehabilitation Service (SRS) funded 12 Demonstration Center projects to test different strategies for child abuse treatment, education and coordination.

At the same time, OCD funded 11 Resource Development projects designed to increase and improve the delivery of comprehensive services in the areas of child abuse and neglect on a statewide, regional and national scale through training, consultation, technical and planning assistance, information and education, development of manuals, other program and service development, research, promotion of new legislation, and so forth.(71)

Each of the projects share a number of common aims:

- Intensive and responsive intake and diagnostic services, including 24-hour hot-lines for emergency reporting.
- Multi-disciplinary diagnostic review of child abuse (and neglect).
- Coordination and integration of public and private service delivery resources.
- Intensive support services, such as crisis nurseries, day care, professional therapy, lay therapy and use of volunteers, homemakers.
- Community, professional and parent education.

At about the same time that OCD and SRS funded these projects, the Health Resources Administration (HRA) funded Berkeley Planning Associates, Berkeley, California to evaluate them.(72) Using the findings of this Evaluation of the National Demonstration Program in Child Abuse and Neglect, Berkeley Planning Associates expects to suggest policy and program recommendations in the following areas:(73)

- Which treatment modalities and service strategies appear to have the most impact on families and to be cost effective?
- What kinds of organizational structures for programs appear to be most effective for implementing treatment and intervention strategies in different kinds of communities?
- What management and information systems are needed for efficient planning, implementation, management and monitoring of local community programs?
- What problems can be expected to arise in various communities as they initiate responses to child abuse, and how can such problems be handled, or avoided, successfully?
- What alternative models for community service delivery systems have been shown to be effective, efficient and feasible for adoption?
- What policies and support from the federal government would facilitate successful program implementation in local communities?

The final results of this evaluation and other federally funded evaluation and research programs pertaining to child abuse will not be available for several years. In the meantime, communities which decide to make serious commitments to tackling child abuse problems in effect have to anticipate the results of these demonstration projects, with or without the aid of federally funded resource development projects, and choose from among alternative intervention and service strategies. A primary purpose of this Prescriptive Package is to offer states and communities additional options for pilot testing of comprehensive changes in intervention strategies and models for handling suspected child abuse.

D. Overview of Problems in the Civil and Criminal Law Process

1. *Civil court process.* Most child abuse cases that do reach courts appear in juvenile or family court, rather than adult criminal courts. Juvenile court (or juvenile sessions of district courts or family/ domestic relations courts) in all jurisdictions have the statutory responsibility to protect endangered children. A dependency or neglect petition is usually filed when any one of the following conditions or situations exist:

- Severe injury, i.e., broken bones, head injury, burns, multiple bruises.
- Repetitive abuse and neglect.
- Child believed to be in immediate danger.
- Efforts have been made to improve the home situation on a voluntary basis by the public social service agency and other agencies have been nonproductive, i.e., appointments not kept, resistance to involvement, lack of consistent medical care.
- Parents inability to care for or protect the child.
- Parents refuse services and child is being neglected or abused.
- Long term planning is needed, i.e., child has been in and out of foster care on voluntary agreement with repeated placements with no real long range plans for the child.
- Child is hospitalized and "Hold Order" is needed, i.e., the parents are threatening to remove the child from the hospital and immediate intervention is indicated.
- Where the police have taken a child into custody for protective custody and placement should continue. (Parents either will not sign voluntary agreement or court ordered placement appears preferable.)
- The public social services agency seeks issuance of a restraining order.

Differentiation in court handling of child abuse is along the following dimensions:

- *Severity of injury.* With local publicity surrounding severe abuse, all the pressures of the system come into play. For example, the D.A. finds it difficult to resist public pressure, even if the abuse represents a single episode. Dependency and neglect actions also hinge on the severity of injury—protection of the child is the court's first consideration.
- *Family history.* Other reported incidents of abuse are considered. Also considered is whether the family is transient or permanent residents of the community—whether they would be available for treatment. (In some communities, a high percentage of the cases before the court are military fam-

ilies, in which cases the court may retain custody.)*

- *Reports and advice of professionals.* Removal of the child for some period is quite frequent, with the conditions that the parents submit to counseling. If the parents display effort in the counselling process, the child may be placed back home for a probationary period, under the supervision of the public social services agency, with periodic medical examinations, and the stipulation of continued treatment.

In dependency cases, the juvenile court has two basic alternatives: to allow the child to remain in the home under supervision, possibly under the temporary custody of the public social services agency, or to remove the child from the home, awarding temporary custody to the public social services agency, which will then place the child in foster care. Juvenile judges and referees usually act conservatively in child abuse cases, preferring to "play it safe" when there is any risk to the child. This protects the child from immediate harm, and the judge from possible criticism, but in many cases it may not be the best disposition.

Some courts attempt to deal with the complexities and uncertainties of abuse cases by extending the pre-trial process as long as possible in contested cases in order to establish enough social-psychological information to frame a more satisfactory disposition—with the participation of parents. But this can be a very time-consuming process which is a luxury for most juvenile judges with crowded court calendars.

Judges stress that under the law the primary purpose of the court is to restore the child to the home. Removal time, however, frequently exceeds six months. If "temporary" removal extends to a year or beyond, the likelihood of return diminishes. Judges state that sometimes it is better for a child to be left in a mildly abusive but stable natural home.

Most judges we have interviewed at best are ambivalent about the effectiveness of civil court as an instrument for dealing with child abuse. Some judges feel it is a very ineffective tool. Where a judge sits in a family court that is part of a trial court of higher jurisdiction, there is a much more optimistic and positive view of the role of the court in handling child abuse cases. Criminal filing is viewed as necessary for the "peace and tranquility of the community." But even if convicted, a person may have more children, and still remain under stress. There is no education of parents. Because court procedures themselves tend to be harsh, court action may reinforce the harshness of the parents' behavior. Judges see dependency and neglect petitions as necessary for removal of a child so that it can't be reabused. But parents may have more children, and the court can't prevent their abuse.

Judges feel that treatment often is not notably effective under court pressure; the more serious the case, the less effective is treatment. Judges believe that there is a need for earlier detection of people likely to be abusers. The court is aggressive, it has the authority to strike out at parents, and can jail parents if they don't get counseling. However, the court deals with parents in a way that may feed the phenomenon of child abuse; it usually is not a constructive influence.(74) There is a need for less aggressive treatment of parents. By the time a child abuse case gets to court, it is a very aggravated situation.

Approaches suggested by judges to promote earlier identification, reporting, and treatment include the following:

- Detect symptoms of abuse earlier - through schools, for example, although this would not protect infants.
- Increase general community acceptance of the responsibility for reporting.
- Provide greater financing for supporting services at earlier stages - with voluntary cooperation on the part of the parents (for example, precrisis counseling).
- If the parents will not cooperate at the precrisis stage there should be increased intervention in child welfare situations in less concrete events than child abuse.

In some states, such as California,* there is a dual system — civil and criminal — of handling child abuse cases which leads to duplication of all processes and investigations.(75) Since very few adult prosecutions take place, consolidation of cases, say in one family court proceeding, would make a great deal of sense. Under the current dual system, juvenile courts have no direct jurisdiction over parents. The indirect power over parents in juvenile court is through their power over the child. In other words, the child becomes the pawn, which we have found to be a problem in juvenile courts across the country which lack authority over the parents directly. If the court's orders in child abuse cases would be enforceable through criminal contempt powers, two possible benefits would result: at least deferral of the extreme remedy of child removal; and less need to use the criminal process in order to acquire power over adult behaviors.

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*See Appendix III (III-3).

*See Appendix III (III-5 and III-10)

An additional and very critical problem in all courts is the quality of judicial personnel and their lack of experience with child abuse cases. This problem is exacerbated in juvenile courts relying on untrained referees to handle child abuse cases and, even where the quality of referees is high, their performance in child abuse cases could be improved with suitable training combined with selection of one or two referees to specialize, perhaps on a rotating basis, in hearing abuse cases.

2. *Criminal court process.* Child abuse may be criminally prosecuted either under a specific statute making child abuse punishable as a crime or under general criminal statutes governing assault, homicide, and the like. As indicated in the preceding section, civil proceedings may be initiated concurrently with the criminal proceeding. Where law enforcement agencies are among the report recipients, the likelihood of a criminal prosecution may be greater. The final decision to prosecute, however, as is the case with other crimes, is made by the city/county attorney or the District Attorney. The District Attorney may either receive reports of all suspected abuse cases or only those cases showing the more severe types of abuse. In general, criminal sanctions are sought in cases of murder, manslaughter, first degree assault, and sexual assault or incest.

Child abuse cases often are very difficult to prove beyond a reasonable doubt. They are usually based on circumstantial evidence. The victim usually is too young or too frightened to testfy. Often there are no witnesses. The mate of the suspected abuser usually denies knowledge of the incident. In the final analysis, cases often depend on medical testimony from physicians who are reluctant to testify, especially given the difficulty of establishing a medical diagnosis beyond a reasonable doubt. For these reasons, prosecutors are likely to proceed with only the strongest cases. Defendents in such cases are likely to plead guilty in return for leniency sentencing. Consequently, few child abuse cases actually proceed to trial and, for the same reasons, "plea bargaining" is viewed as essential by most district attorneys.

E. Summary of Conclusions

1. *Summary of Literature Review Conclusions.* Community intervention to deal with child abuse, especially within the legal system, generally lacks any solid relationship to what we know or don't know about the multiple causes and manifestations of child abuse. As the statutory definition of child abuse broadens, community intervention (1) is based on a knowledge base that is extremely limited conceptually, empirically, and methodologically, and (2) increasingly is committed to dealing legally with a myriad of social and economic ills without a commensurate commitment of the resources necessary to meet basic needs for goods and services that facilitate adequate parenting.

A key to diagnosis and appropriate intervention in child abuse cases would be research that leads to better criteria for case assessment of the causes, nature, and severity of the problem; the role of psychological, social, and environmental factors; and assessment of probable outcome and potential reversibility. In general the research available does not support the kinds of simple non-conflicting generalizations that practioners in law enforcement or protective services can translate into decision-making criteria.

Little is known about whether community intervention—legal, social, medical, mental health—makes any difference in terms of children having been saved from further physical abuse. The impact of coercive legal power on abusing families similarly is unknown. The legal system of intervention, including protective services, is built on the theory or principle of serving and protecting the "best interests of the child." But no systematic studies of the process and outcomes exists to offer evidence as to whether the legal system or protective services either achieve this goal or inadvertently defeat it.

Most aspects of child abuse intervention in our society appear to be based on myths, hunches, speculations, educated guesses, inadequate or incomplete data, biases of information gatherers and users, professional predelictions, wishful thinking, fantasy, and so forth, but not on experimental research data or other hard data.

In our review of the literature on child abuse, we have found no substantial research evidence that:

- Protective service or social work intervention is preventative or curative for parents who have allegedly abused their children and may abuse others.
- Social work intervention is more effective than police intervention in alleged abuse cases.
- Court processing is more psychologically harmful or otherwise damaging than social work intervention in alleged abuse cases.
- Psychotherapy or social work or punishment is more or less effective than emergency cash or income improvement for suspected abusive parents.
- Universal day care might solve the child abuse problem as quickly and effectively as a vast expansion of protective services.
- Jailing more adjudicated abusive parents might be more curative (or harmful) than social working them; conversely, social working abusive parents might be more curative (or harmful) than jailing them.
- The adverserial court process is more harmful to alleged abusive parents than the purportedly benign pre-court process.
- Abusing parents have had abusing parents, except among poor or less affluent families reported as suspect abusers.
- Information compiled on abusing families is more beneficial, for diagnosis or any other purpose, than discarding such information.
- Multi-disciplinary teams make more sound treatment/service or prosecution recommendations than police officers or protective service workers.
- Protective service workers, police or probation officers, doctors or other professionals can be trained to make more effective decisions about identification, validation, prosecution, or treatment of alleged abusive families.
- Removal of children from suspected abusing families is more beneficial than leaving them at home, perhaps with homemaker follow-up.
- Child abuse would disappear if inequalities in income and social status disappear.
- Child abuse cannot be reduced until income inequalities or the violence-orientation of the society is reduced.
- Reporting laws, central registries, civil and criminal prosecution of cases controls or reduces or increases the incidence of child abuse.
- Any of the proported incentives for reporting (civil and criminal immunity) or penalties (criminal penalties for non-reporting) or tools to gain evidence (abrogation of confidentiality) accomplish their aims.

The litany of unknowns and uncertainties in the field of child abuse (and neglect) appears to be virtually limitless.

2. *Summary of conclusions regarding child abuse handling practices.* Our review of the intervention roles and practices of community agencies, especially in the initial stage of handling suspected child abuse cases, leads to the following conclusions relevant to the design of a model system:

- The choice of initial intervention agency is crucial insofar as it determines the nature of subsequent processes and outcomes for both parent and child.
- A multiplicity of possible entry points into the noncriminal and criminal tracks or systems for handling suspected child abuse creates conflict, confusion and counterproductive patterns of institutional responses, especially when the criminal track controls the initial decision-making process.
- Limiting the scope of cases entering the criminal track is necessary, in the interests of developing a humane, non-punitive and treatment-oriented system for handling suspected child abuse, but criminal prosecution of severe or fatal cases continues to be an option of the justice system.
- Whatever agency is designated under law as responsible for initial intervention in suspected child abuse in each geographic subdivision of a state should be capable of institutionally, functionally, and in role image, divorcing itself from and operating independently of the law enforcement track or system, civil or criminal, and yet possess the requisite measure of intervention authority; be compatible with protective services that institutionally and legally cannot shed its problematic dual role; and should be philosophically and functionally compatible with a medically-based diagnostic process which has its locus in hospitals with specially developed capabilities for

decision-making on serious child abuse cases.

- Highly qualified, experienced and adequately skilled staff to perform the initial intervention and diagnostic responsibilities are critical for the complex, sometimes life or death, decision-making process from identification of suspected abuse cases to medical verification and possible referral for legal action.
- The initial intervention process should narrowly focus on the medical diagnostic aspects of injuries to children, limit service to emergency services related to the specific conditions or circumstances that contributed to or precipitated the incident subject to state intervention, and minimize the need for coordination and the number and variety of official interactions between different agencies and individuals in the social-legal-medical agencies traditionally involved in handling such cases.
- A single agency is necessary to have *full responsibility* for the *initial* intervention in child abuse cases *as child abuse cases*, rather than welfare agencies handling them as social work cases, police handling them as criminal cases, and hospitals handling them as medical cases, exercising discretion in a variety of ways depending on the purposes and professional orientations of the agencies involved.
- Systematic revamping of the current child abuse handling system, especially the tracking system, from initial identification and investigation to initiation of the legal process in appropriate cases, is an essential prerequisite for public education to stimulate increased public reporting and possibly generate increased self-reporting.
- Protection of the child must be the foremost concern of a new system of handling abuse cases, but removal of the child from the home, frequently for a long term and without provision for family treatment, as the most potentially harmful and punitive aspect of the existing system, should be strictly limited in accordance with clear standards keyed to forcing assessment of alternative treatment measures.

These nine primary conclusions drawn from an analysis of roles and practices in the existing child abuse handling systems provide the rationale for a new system proposing to *utilize trained professionals in the existing public health and hospital track as the initial specialized intervention and entry sub-system for a non-criminal diagnostic and civil legal process of handling suspected child abuse.*

Current law and practices pertaining to the handling of child abuse cases from initial identification to the possible initiation of court processes raise numerous general and specific issues and questions that have to be directly or indirectly addressed in any model system. Appendix II contains a compilation of these issues and questions. Many of the issues and questions listed in Appendix II are reflected in Part III of the Prescriptive Package which presents, in question-and-answer format, how each key decision-maker involved in the model system should handle physical child abuse cases.

NOTES

(1) Elizabeth Elmer and John Reinhard, *Child Abuse: A Handbook* (Rockville, Maryland: NIMH Center for Studies of Crime and Delinquency).

(2) David G. Gil, *Violence Against Children* (Cambridge, Massachusetts: Harvard University Press, 1970). [AB#4]

There exists in American society a "cycle of violence" which partially sanctions individual acts of violence against children by association with collective acts against them—poverty, discrimination, and "spare the rod, spoil the child" child-rearing practices.

David G. Gil, "A Holistic Perspective on Child Abuse and Its Prevention," *Journal of Sociology and Social Welfare*, vol. II, no. 2 (Winter, 1974). [AB#98]

Gil's analysis suggests that primary prevention of child abuse would require fundamental changes in value premises, in societal institutions, and in child-rearing.

(3) Maure Hurt, Jr., *Child Abuse and Neglect: A Report on the Status of the Research* (U.S. Department of Health, Education and Welfare, Office of Human Development/Office of Child Development), p. 5.

(4) *Ibid.*

(5) Henry C. Kempe *et al.*, "The Battered Child Syndrome," *Journal of the American Medical Association* 181 (1) :17-24 (July 7, 1962). [AB#24]

(6) John Caffey, "The Parent-Infant Traumatic Stress Syndrome: (Caffey-Kempe Syndrome), (Battered Baby Syndrome)," *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine* 114:218-229 (February,, 1972). [AB#24]

(7) Brandt F. Steele and Carl B. Pollock, "A Psychiatric Study of Parents Who Abuse Infants and Small Children,"

The Battered Child, Helfer and Kempe, eds. (University of Chicago Press, second edition: 1974), p. 95 [AB#37]

"It is hardly an exaggeration to say the parent acts like a frightened, unloved child, looking to his own child as if he were an adult capable of providing comfort and love. This is the phenomenon described as 'role reversal' by Morris and Gould."

(8)*Ibid.*

Case studies are described in detail, with special attention to patterns of behavior in child-rearing. The author claims that, without exception, these parents recreate the style in which they themselves were raised with their own children.

(9)David N. Daniels *et al.*, *Violence and the Struggle for Existence* (Boston, Massachusetts: Little, Brown and Company, 1970). [AB#2]

(10)Leontine Young, *Wednesday's Children* (New York: McGraw-Hill, 1964). [AB#39]

(11)Caffey, n. 6 *supra*.

(12)Stephan J. Cohen and Alan Sussman, "The Incidence of Child Abuse in the United States," (New York: Institute of Judicial Administration, Inc., American Bar Association, Juvenile Justice Standards Project, November, 1974) (Unpublished Manuscript). [AB#90]

(13)Vincent DeFrancis and Carrol L. Lucht, *Child Abuse Legislation in the 1970's* (Denver, Colorado: American Humane Association, Children's Division, 1974). [AB#92]

This is a comprehensive volume containing the child abuse statutes for all 50 states, plus definition and analysis of these statutes. It is updated periodically to reflect recent legislative changes.

(14)Richard L. Light, "Abused and Neglected Children in America: A Study of Alternative Policies," *Harvard Educational Review*, November, 1973, pp. 556-598. [AB#34]

Out of 3,000 reported cases of child abuse in New York City in 1973, only 8 were reported by private physicians. Similar proportions have been evidenced in data collected from other cities and many experts argue that this particular bias leads to the far greater likelihood of reports on low-income families than on their middle-class counterparts.

(15)Brian G. Fraser, "A Pragmatic Alternative to Current Legislative Approaches to Child Abuse," *The American Criminal Law Review*, vol. 12, no. 1 (Summer, 1974), pp. 103-124. [AB#95]

While all 50 states require physicians to report suspected cases of child abuse, other persons required to report include nurses (34 states), social workers (25 states), teachers (24 states), and police officers (9 states).

(16)Stephan J. Cohen, *A Study of Child Abuse Reporting Practices and Services in Four States* (New York: Juvenile Justice Standards Project). [AB#49]

(17)Stephan J. Cohen and Alan Sussman, *Model Child Abuse and Neglect Reporting Law* (Juvenile Justice Standards Project, January, 1975) (Draft Manuscript). [AB#12]

(18)Cohen, *Child Abuse Reporting Practices and Services*, n. 16 *supra*.

(19)*Ibid.*

(20)*Ibid.*

(21)*Ibid.*

(22)Fraser, n. 15 *supra*.

(23)*Model Child Protective Services Act* (Office of Child Development, of Health, Education and Welfare, July 7, 1975).

(24)Marvin R. Burt and Ralph Balyeat, "A New System for Improving the Care of Neglected and Abuse Children," *Child Welfare*, vol. LIII, no. 3 (March, 1974), pp. 167-179. [AB#46]

(25)Elizabeth Davoren, "The Battered Child in California: A Survey, *San Francisco Consortium*, March, 1973. [AB#50]

(26)Cohen, *Child Abuse Reporting Practices and Services*, n. 16 *supra*.

(27)Lenore C. Terr and Andrew S. Watson, "The Battered Child Rebrutalized: Ten Cases of Medical-Legal Confusion," *American Journal of Psychiatry*, April, 1968, pp. 126-133. [AB#83]

(28)Harvey A. Barocas, "Urban Policemen: Crisis Mediators or Crisis Creators," American Journal of Orthypsychiatry, 43(4):632-639 (1973). [AB#87]

(29)Douglas J. Besharov, *Juvenile Justice Advocacy - Practice in a Unique Court* (New York: Practicing Law Institute). [AB#42]

(30)*Ibid.*

(31)Henry C. Kemp and Ray E. Helfer, eds., *Helping the Battered Child and His Family*, "The Status of Child Protective Services, A National Delimma" (Philadelphia, Pennsylvania: J. B. Lippincott Co., 1972). [AB#69]

(32)*Ibid.* "The Child's Need for Early Recognition, Immediate Care and Protection." [AB#30]

(33)*Ibid.* "The Consortium - A Community-Hospital Treatment Plan." [AB#68]

(34)Thomas J. Donovan, "The Legal Response to Child Abuse," *William and Mary Law Review* 960 (1970), pp. 960-987. [AB#93]

(35)H. Rodham, "Children Under the Law," *Harvard Educational Review* 43:487-514 (1973). [AB#110]

(36)Fraser, n. 15 *supra*.

(37)Vincent J. Fontana, *Somewhere A Child is Crying: Maltreatment - Causes and Prevention* (New York: Macmillan, 1973). [AB#13]

(38)Sanford N. Katz, *When Parents Fail: The Law's Response to Family Breakdown* (Boston, Massachusetts: Beacon Press, 1971). [AB#99]

(39)Robert H. Mnookin, "Foster Care - In Whose Best Interest?" *Harvard Educational Review*, vol. 43, no. 4 (November, 1973), pp. 599 -638. [AB#70]

(40)*Ibid.*

(41)Robert L. Geiser, *The Illusion of Caring - Children in Foster Care* (Boston, Massachusetts: Beacon Press, 1973). [AB#56]

Geiser discusses the approximately 364,000 American children who are in foster care because their families have failed "to function as expected in our society."

(42)D. Fanshel and E. B. Shinn, *Dollars and Sense in the Foster Care of Children: A Look at Cost Factors* (New York: Child Welfare League of America). [AB#54]

(43)Alan R. Gruber, *Foster Home Care in Massachusetts - A Study of Foster Children, Their Biological and Foster Parents* (Commonwealth of Massachusetts, Governor's Commission on Adoption and Foster Care, 1973). [AB#59]

(44)Mnookin, n. 39 *supra*.

(45)Fontana, n. 37 *supra*.

(46)Geiser, n. 41 *supra*.

(47)Richard Levine, "Foundations for Drafting a Model Statute to Terminate Parental Rights" (Prepared for the Neglected Child Committee of the National Council of Juvenile Court Judges, 1975) (Unpublished Draft).

(48)Monrad G. Paulsen, "The Legal Framework for Child Protection," *Colombia Law Review* 66 (1966) pp. 679, 710-717. [AB#107]

(49)Besharov, n. 29 *supra*.

(50)James J. McKenna, "A Case Study of Child Abuse: A Former Prosecutor's View," *The American Criminal Law Review*, vol. 12, no. 1 (Summer, 1974), pp. 165-178. [AB#102]

(51)Eli H. Newberger, M. D., "The Myth of the Battered Child Syndrome," *Current Medical Dialog*, vol. 40, no. 4 (April, 1973). [AB#72]

Newberger refers to the fact that public welfare departments are finding it impossible to cope with the ever-increasing number of reported child abuse cases; and the situation will grow worse with the trend towards broader reporting laws.

Eli H. Newberger, M.D. and James N. Hyde, "Child Abuse: Principles and Implications of Current Pediatric Practice" (Pediatric Clinic of North America, August, 1975). [AB#73]

In this article, it is asserted that availability of viable alternatives for abusive families (i.e., homemakers, child care, counseling, and foster care) are costly and difficult to obtain. At present, few if any states have adequate personnel and resources to deal with the increasing number of cases reported.

(52)Kempe and Helfer, eds., *Helping the Battered Child* and *His Family*, "Status of Child Protective Services," n. 31 supra.

Inadequate funding and staffing of child protective service agencies (both public and private) creates a situation where either quality and extensiveness of services are sacrificed so that more cases can be handled or intake is arbitrarily limited so that better casework and follow-up occur.

(53)E.G. Meier, "Child Neglect," *Social Work and Social Problems*, N. E. Cohen, ed. (New York: National Association of Social Workers, 1964). [AB#17]

Among parents who are neglectful or in danger of becoming neglectful are those overwhelmed by external pressures and those unaware of community standards of care. There are also those with severe defects in ego development. Many aspects of the social worker's training—e.g., permissiveness, acceptance, explorations of client's own deprivations—are inappropriate to the task of working with clients with ego defects who may require limits and use of authority.

Andrew Billingsly, *The Role of the Social Worker in a Child Protective Agency: A Cooperative Analysis* (Massachusetts Society for the prevention of Cruelty to Children). [AB#343]

This study contrasts the role performance of a caseworker in a family counseling agency, who works mainly with the client, with that of a protective agency worker, who must spend a large amount of time in community activity. Role differences revolve around the fact that the caseworker in a family counseling agency is dealing with clients who come to the agency for help; while the caseworker in a child protective agency must intervene in family situations where parents have not asked for help.

(54)Cohen, *Child Abuse Reporting Practices and Services, n. 16 supra.*

Major Findings of this study showed the following weaknesses in the existing system:

1). Underreporting, due to unfamiliarity with law, fear of legal involvement, and fear that reporting would not be constructive because of the lack of available treatment services.
2). Poor training and educational programs for professionals and lay people in identifying and reporting child abuse; there is little knowledge of the availability of support services.
3). Lack of available services as alternatives to court processing.
4). Lack of interagency cooperation and coordination.
5). Lack of 24 hour reporting facilities.
6). The high degree of discretion in the reporting and handling of child abuse.
7). "The most crucial finding. . .was the lack of congruence between the system for reporting suspected abuse and the system for delivery of services.

(55)Richard S. Levine, "Caveat Parens: A Demystification of the Child Protection System," University of Pittsburgh Law Review 1 (1973). [AB#101]

Levine is concerned with the initial interventions of child protective service agencies. The demystification he seeks involves the social workers projected imagery of friendliness and benevolence. He presents a long list of the faults of present social work efforts and foster care programs. Greater and more frequent judicial review of child protective services activities is needed along with procedural safeguards for parents, especially, where so-called "voluntary" entrustment agreements are involved. Agencies should be required to show that a plan for the rehabilitation of the family *unit*, not solely for the child, is available and has been offered before intervention is authorized. A "right to treatment" should become the quid pro quo for the state's right to intervene. Procedurally, a search warrant should be required to be obtained by a child welfare investigator before entry into the home; parents should be granted and informed of their Fifth Amendment privilege to refuse to answer any questions; parents should be granted the right to consult with an attorney at any stage; and they should have the right to court review of agency action.

(56)Larry B. Silver *et al.*, "Child Abuse Syndrome: The 'Gray Areas' in Establishing a Diagnosis," *Pediatrics* 44(4):594-600 (1969). [AB#82]

Exploration of situations in which physician found it difficult to establish or rule out the diagnosis of child abuse. In such cases, the major issues were the physician's subjective personal feelings, his misunderstanding of the child abuse laws, and his role and responsibilities. The five main reasons for non-reporting were indicated as: (1) subjective interference where the child abuse diagnosis was rarely considered (28%); (2) benefit of the doubt - physicians tended to accept even the most implausible rationale for injury (19%); (3) responsibility for act uncertain - the physician was unable to positively identify the abuser (19%); (4) parental privilege to punish (6%); and (5) effects of alcohol rendered abuser unconscious of actions (17%).

Terr and Watson, n. 27 *supra*.

Another factor in underreporting of child abuse cases is a traditional over-confidence of doctors and psychiatrists in successful therapy if the cases remain voluntary.

David G. Gil, "The Many Faces of Violence Against Children," *Testimony before the U.S. Senate Sub-committee on Child and Youth on the "Child Abuse Prevention Act" - S.1911* (93rd Congress, 1st Session, March 26, 1973). [AB#97]

Reported incidents involve almost exclusively abuse of children in their own homes; public authorities seem reluctant to keep records of child abuse in the public domain (e.g. schools and public institutions).

(57)Cohen, *Child Abuse Reporting Practices and Services*, n. 16 supra.

(58)*Ibid.*

Terr and Watson, n. 27 *supra*.

Donovan, n. 24 *supra*.

The author advocates providing a choice of reporting to public welfare agencies (in cases of minor abuse, where criminal sanctions might provoke further resentment against the child), or law enforcement agencies (if abuse was severe and the child is in danger). This would circumvent the reluctance of many physicians to report relatively minor abuse to police, founded in the belief that law enforcement action would cause the situation to worsen.

(59)Kempe and Helfer, eds., *Helping the Battered Child*, "The Consortium," n. 33 supra.

"When the doctor finds a given agency uncooperative, he is placed in a very difficult position. He may feel that the child is at great risk. . . and yet may be unable to convince a specific law enforcement or child welfare agency to bring dependency proceedings to the court. . .One of our children was still at home after his eleventh fracture because the child welfare agency was unwilling to file a dependency petition."

(60)Donovan, n. 34 *supra*.

The author discusses reports which are typically made to law enforcement agencies or prosecutors; or to public welfare agencies which may or may not be required to investigate incidents and report to law enforcement agencies if criminal prosecution is warranted; directly to the court which then directs a public agency to investigate; or simultaneously to law enforcement and public welfare agencies.

(61)Gary S. Goodpaster and Karen Angel, "Child Abuse and the Law: The California System," *Hastings Law Journal* 26, no. 5 (March, 1975).

"No single agency is responsible for handling child abuse cases as *child abuse cases*. . .from a social policy point of view, an important choice must be made here: each agency can maintain its current operations; each can participate in a coordinating body; or some new or consolidated agency can be given principal responsibility for the tracking and handling of child abuse cases, overseeing their progress through the system from beginning to end. . .and keeping its own records on all of these matters. The latter alternative is obviously recommended here, for fragmentation of responsibility seriously interferes with the best resolution of child abuse cases."

(62)Newberger and Hyde, n. 51 *supra*.

"One may thus be torn between one's legal responsibility to report and one's clinical judgement which may suggest that reporting itself may jeopardize the opportunity to develop a satisfactory treatment program for the family. Often this conflict is expressed in reticence to inform families that they are being reported, reluctance and even frank refusal to report cases of abuse and neglect."

"While there are no cut and dried decision rules which resolve this conflict definitively, two simple guidelines make it easier for the mandated professional to come to terms both with his/her legal responsibility and clinical judgement. . .While such an approach may palliate the anxiety of reporter and family, it does not remove the real, inherent labeling and stigmatizing aspects of the reporting process as it exists in most of the States today."

(63)Katz, n. 3 *supra*.

Public intrusion into neglecting families is divided into four stages: report, investigation, challenge and state intervention. The report can come from a wide range of sources, and to a wide variety of agencies. There are few legal standards and reporting is as often the result of economic, ethnic, or personal factors as it is the result of the application of legal standards. Reporting primarily involves the urban lower classes who are more visible because their lives are more public, whereas the suburban middle classes have more privacy and benefit from a presumption of their neighbors that they are fit parents. The role of police in domestic matters is also more passive in suburban than in urban areas.

(64)Cohen, *Child Abuse Reporting Practices or Services*, n. 6 *supra*.

Reporting is negatively effected by the issue of what poses the greater risk for the abused child—not reporting, or involvement in court process and the ensuing "basic remedy" of the system: long-term removal with no treatment provision for the family.

(65)J. M. Cameron, H. L. M. John and F. E. Camps, "The Battered Child Syndrome," *Medicine, Science and the Law* 6 (January, 1966), pp. 2-21 [AB#47]

(66)Saad Z. Nagi, "The Structure and Performance of Programs on Child Abuse and Neglect" (Submitted to the Office of Child Development, Department of Health Education and Welfare, Grant No. OCD-CB-500 C1), Mershon Center, Ohio State University, Columbus, Ohio (March, 1975). [AB#71]

(67)Associated Press, "Child Abuse Getting Worse in Miami Area," August 28, 1975.

(68)*Ibid*.

(69)Nagi, n. 66 *supra*.

Counseling was the service most often mentioned as lacking by respondents from all agencies. Home support, placement facilities and financial support were also frequently indicated. Problems in interagency coordination and inadequacies in manpower and staff qualifications have already been pointed out as two major impediments to program effectiveness.

(70)Saad Z. Nagi, "Child Abuse and Neglect Programs: A National Overview," *Children Today*, May-June, 1975. (All figures regarding the Florida system reflected in the following paragraphs can be referenced to this article.)

(71)The demonstration centers are responsible for total management of child abuse and neglect cases, including investigation, assessment, treatment, referral, public education, 24-hour hotlines, supportive services, and coordination with other agencies. Projects use inter-disciplinary teams of professionals who focus on treating and maintaining the family as a unit.

The demonstration resource projectes are mandated to promote more effective use of resources within communities, strengthening their capacity to cope with child abuse and neglect problems. Technical assistance is provided to state and local programs to help them initiate or improve services, and training is available to professionals and community agencies.

(72)BPA has been charged with the task of evaluating the 11 demonstration projects in order to provide evaluation evidence of the effectiveness of the community intervention strategies as well as to provide guidance to the Federal Government and local communities on the development of community-wide child abuse programs. To achieve these purposes, the specific objectives of the evaluation include: providing assistance to individual projects and the overall demonstration program; monitoring the implementation process of each project; initiating in each project a system for assessing impact on communities; the development of methods for assessing the impatt on abusive or neglectful parents and children of services received; the determination of relative effectiveness and cost-effectiveness; and providing useful summative information to the Federal Government and to the individual projects.

(73)Anne Harris Cohn, Susan Shea Ridge and Frederick C. Collignon, "Evaluating Innovative Treatment Programs in Child Abuse and Neglect," *Children Today*, May-June, 1975, pp. 10-12.

(74)This opinion was stated by a judge interviewed during one of our site visits.

(75)Goodpaster and Angel, n. 61 *supra*.

CHAPTER II. STRATEGY OF THE MODEL SYSTEM

A. Purposes, Goals and Objectives

At the center of the controversy over governmental policies toward child abuse is the issue of whether or not child abuse should be treated as a socio-medial phenomenon distinct from other forms of maltreatment of children, thereby warranting special policies, programs, procedures, etc. Our view is that childrens' afflictions *and basic needs* for healthy development should be viewed within a continuum and that, under ideal circumstances, public policy and program development should equitably span that continuum. However, politics, institutions, and resource allocation processes in this country discriminate against children; and, as a practical matter, relative to defense or energy resource problems, appear to care little about children's best interests.

Until society as a whole can recognize the efficacy and value of enabling all children to thrive, rather than waiting to act until they fail to thrive, there is a realistic need to set priorities for public intervention into child maltreatment. The model system sets that priority where the severity of consequences may be greatest for children—in instances of physical abuse.

Medical professionals and others convincingly argue that the consequences of neglect can be equally damaging to children's capacity to function normally. From the available research reviewed in Appendix I, the merits of this argument have to be acknowledged. Our rejoinder, however, is to suggest that, prior to enactment of the Child Abuse Prevention and Treatment Act in 1974, there was no national focus for the tasks of coping with child abuse or neglect. Therefore, the development of adequate community intervention systems—social, medical, legal, and so forth—still is at the earliest stage.

The tasks of developing effective services are made much more difficult by the nature of existing institutions, agencies, and systems (or non-systems) which are ill-equipped for new or intensified responsibilities in identification, prevention and treatment of child abuse and neglect. No one is really sure how to do any of these things—identify, prevent, or treat. We lack reasonably reliable knowledge of the incidence of "maltreatment" generally or physical child abuse. There continues to be the difficulty of specifying and standardizing the parameters of these cases.

In view of the present "state of the art," whatever is done by government in cooperation with private agencies in the area of dealing with maltreatment of children has to be viewed as experimental and requiring special safeguards against the kinds of "knowledge overreach" and "legalistic overkill" that characterize current child protection efforts. In this regard, the purposes and goals of the proposed model child abuse intervention system seek to create a realistic and reasonable balance between:

- The use of state authority to intervene in child abuse cases, and the capacity of public and private resources for follow-up and treatment.
- Protection of the child from reinjury, and the rights of parents and children individually and as a family unit.
- The concerns of the state about physical child abuse prevention and treatment, and concerns about other parental responsibilities enforceable by law;
- The legitimacy of state legal intervention to protect children from physical abuse, and the limitations of the legal system to positively contribute to changes in the behavior of abusive parents.
- The need to identify physical child abuse so as to treat it and prevent its recurrence, and the limitations of law to encourage reporting and the hazards of excessive quasi-legal and legal intervention for case-finding purposes.
- The advantages and disadvantages of continuing ongoing "imperfect" parent-child relationships with those of the alternative placements that can be made available.

The purposes of the system proposed in this handbook are limited and realistically based on what is known about child abuse. These purposes are:

- To identify and medically treat incidents of *physical* child injury brought to the attention of medical professionals by persons responsible for their welfare.
- To determine whether the injured child or other siblings are at risk in order to prevent reinjury by means of follow-up and treatment that: assures the child's physical safety; minimizes discretionary intrusion in the family's life situation; minimizes child removal in terms of occurrence and length of time; and maximizes the provision to the persons responsible for the child of tangible help that is directly related to the prevention of physical reinjury or injury; and that assures protection of the legal rights of parents/custodians and children.

These general purposes and goals of the model system establish the framework for the following set of *strategies and objectives for system development*:

- The definition of child abuse should be limited to the original Kempe-Helfer conception of the "Battered Child": non-accidental, medically diagnosable physical injuries.
- By narrowing the definition of child abuse to inflicted injuries (excluding sexual, emotional, mental, medical and drug abuse), proper medical diagnosis becomes the key to pre-court verification of child abuse. A hospital or other medical facility (designated as a Child Injury Medical Center or CIMC), licensed by the state to perform child abuse examinations in accordance with specified medical and procedural standards, becomes the primary decision-making arena for diagnostic assessment of all suspected child abuse cases to determine the need for processing of the case in civil court for a legal decision on custody and protective services.
- County, multi-county or local public health agencies (designated as Injured Child Examination Units or ICEU) should designate and train staff to screen all reports of injured children or suspected child abuse (which do not directly enter a hospital) to assess the need for referral of the child to a CIMC for a medical examination and possible treatment.
- The role of protective services should be limited to providing short-term emergency services, at the request of the ICEU or CIMC, and supportive services under informal or formal court dispositions.
- Law enforcement officers should be relied upon for 24-hour emergency response to child abuse reports but, except where a child requires immediate hospitalization or protective custody, the ICEU should be called for examination of the injured child. Police should adopt policies, in collaboration with the district attorney's office, to seek prosecution under criminal laws only in exceptional cases (e.g., homicides or malicious violence).
- Central registers, which thus far appear to be of little value for research, diagnostic, or statistical purposes, probably are harmful and certainly are extremely difficult, if not impossible, to design in a way that protects the confidentiality of the information contained in them. Instead, we propose a limited-purpose "Child Abuse Information File," tightly restricted as to information input and dissemination, that should be established as part of civil court information systems in local jurisdictions (and *not* as a new child welfare-type information system). Accountability monitoring of the performance of the model system as a whole would be provided for under the reporting and monitoring requirements of Title XX of the Social Security Act, administered by the designated Title XX agency in each state, with strict safeguards for the confidentiality of all records and information.
- When protection of the child from reinjury may require placement of any type, including under temporary custody in the child's own home, the civil court process should be initiated as the arena within which this type of decision is made, with parent and child having counsel and the child also having a guardian ad litem.
- The number of children placed in all types of foster care should be limited by judicious use of comprehensive emergency services, from the point of initial identification of a family crisis or breakdown to the point of either resolution of custody questions in a probable cause court hearing

or completion of medical diagnosis of the case by a CIMC.

- The medical diagnostic process for verifying the incidence of inflicted injury should focus on protection of the child rather than collecting evidence of abuse. The diagnostic decision with respect to initiating legal action as well as any decision regarding any type of separation of the child from his/her parents or guardians should use the criterion that the decision is primarily intended to result in or facilitate the least detrimental alternative.
- The model system for handling child abuse should establish a single uniform, well-defined and relatively easily managed track, clearly separate from the punitive criminal justice track, from initial report or identification of suspected abuse, by any source, to a medical diagnostic decision regarding the accidental or non-accidental nature of the presenting injury(s).
- The model system and its components should set well-defined limits on the role, responsibilities and powers of protective service agencies, law enforcement agencies, hospitals, state public welfare agencies, and centralized information systems; avoid the creation of new or redundant layers of bureaucracy in the child abuse handling track; and maximize the use of existing institutions and agencies, accompanied by a significant level of effort to train the people who are responsible for handling child abuse cases.
- At every point in the procedures for reporting, investigating, and verifying the report as well as providing services of any type and making placement decisions, the propriety, feasibility, and possible benefits and risks should be made as explicit as possible to the parents affected; wherever possible, the parents should be present or represented at the decision-making and, likewise, the child.
- The filing of petitions should be reduced to those cases where it is essential to protect the child from imminent danger to life or safety. The responsibility for filing the petition should rest with counsel for the local jurisdiction (e.g., city or county attorney).

B. Definition of Child Abuse

The definition of child abuse is the most critical decision in the development of any system for state intervention. First, it establishes the philosophical and value framework for all subsequent decisions and reflects the society's commitment to the rights and needs of children. Existing and proposed statutes pertaining to abuse and neglect express the philosophy that commissions or omission of certain types of parental acts and parenting behaviors warrant state intervention in order to prevent their reoccurrence or to remedy them. However, in our view, individual manifestations of child abuse and neglect fundamentally result from omission by this society in providing the resources necessary to enable children—as a matter of right—to develop their full potentialities as human beings.

In view of such a commitment, our society has established a wide array of laws intended only to protect children from certain types and levels of harm and deprivation, to correct their asocial or delinquent behaviors, or to bring legal sanctions against their parents for failure to live up to community norms of parenting, regardless of their life circumstances and resources.

Philosophically, therefore, the model system attempts to limit the punitive and detrimental consequences of blaming and stigmatizing the victims of our society's lack of commitment to children's rights to more than minimum protection from harm.

Unless it is clearly understood that we subscribe to a fundamental reordering of national values and priorities to commit sufficient resources to develop and fulfill *all* children's capacities, prior to and after birth, the proposed narrow definition of child abuse can be interpreted as reactionary and lending support to those persons who at best would maintain the status quo.

Second, the definition of child abuse is pivotal because it establishes the conditions which justify intrusion into private family life. The basic rationale underlying most existing child abuse and neglect statutes is that child abuse should be linked with sundry other forms of maltreatment in order to conceptually and programmatically connect child protection and child welfare services; to eliminate or minimize artificially created distinctions and overlapping labels; and to unify and improve the efficiency of case handling. The outcome of this rationale is to maximize the situations in which state intrusion is justified (philosophically), necessary (statutorily), and difficult, if not impossible, to restrain (operationally). The model system's emphasis on legal protections and due process can be viewed as a necessary countermove to the systemic tendencies to over intervention. However, the proposed model system is not grounded in wholly unrealistic optimism as to the effectiveness and justice of our legal system. Here again, our approach essentially seeks to minimize damage to parents and children and, whenever possible, to promote fair legal processes and outcomes.

The intervention strategy proposed in our model system singles out child abuse from other acute medical conditions, such as failure to thrive, accidents and ingestions. We recognize that, from the standpoint of an etiologic classification framework, the isolation of child abuse probably makes little sense. There may be common variables among maltreatment conditions or case categories, as well as distinct causal mechanisms. We don't know because an etiologic taxonomy of these childhood "illnesses" has not yet been adequately researched. Consequently, we also lack methodologies for treatment oriented to the causes of these problems.

We recognize the logic, in the ideal sense, of covering all situations of harm to children necessitating societal intervention under one definition. It is consistent with the strategy choice of strengthening reporting systems prior to expanding prevention and treatment services. However, as explained below, in our model system focused on child abuse we fundamentally question and reject the underlying premises of this broad, conclusory approach to state jurisdiction over child abuse (and other forms of maltreatment) as unrealistic and possibly counterproductive.

During the last 15 years, every state has revised its child abuse reporting laws to some extent. In some states the revisions have been drastic. These changes are continuing, spurred by the recent Federal Child Abuse Prevention and Treatment Act (P.L. 93-247). The definitions of child abuse are being expanded to cover neglect, sexual abuse, and emotional abuse. Under P. L. 93-247, the definition of abuse is expanded to the maximum extent possible:

> ...the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

As legislatures establish broad mandates for reporting and legal or quasi-legal intervention, they have not given the executive branch of government adequate child protection and treatment capabilities. Child protective agencies are both forced and disposed to overuse their authority for protection of children by excessive removal of children from their homes. Child removal in effect too frequently is used judicially to compensate for lack of adequate follow-up and treatment capability. Broadening of statutory child abuse jurisdiction and the related vagueness of decision-making criteria fosters overintervention in terms of the way limited community resources are organized to respond to child welfare needs. For these and other reasons cited elsewhere, the proposed model system adopts a restrictive definition of child abuse—the "battered child"—which runs counter to current trends.

The term "battered child syndrome," as defined by Dr. C. Henry Kempe and his colleagues, characterizes "a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent."(1) Today only a few states still define child abuse in this restrictive manner.(2) The statutory definitions of child abuse have been refined and broadened.(3) Definitions of child abuse tend to follow Fontana's more broadly defined "maltreatment syndrome" where the child "often presents itself without obvious signs of being battered but with multiple minor evidences of emotional and, at times, nutritional deprivation, neglect, and abuse. The battered child is only the last phase of the spectrum of the maltreatment syndrome."(4) The definitions of child abuse have been broadened specifically to include neglect, sexual abuse and, in a few states, emotional abuse.(5) Underlying both narrow and broad definitions of child abuse is the implicit concept of parental fault.(6)

The key issues in definition child abuse are:

- *Should the definition of child abuse be narrow—restricted to physical abuse (i.e., the "battered child syndrome")—or broad—to include neglect, sexual abuse, and/or emotional abuse?*
- *Should the definition of child abuse include the implicit concept of parental fault to be determined in a civil and/or criminal court proceeding?*

1. *Broad versus narrow definition.* The knowledge about child abuse is theoretically and practically very limited. Child abuse data and research mostly focuses on reported or identified cases, which mostly involve lower income or economically disadvantaged families.(7) Hence, child abuse is associated in the literature with families afflicted by poverty-related social and health problems. The broader the definition of child abuse, the more likely that the scope of legal jurisdiction will encompass families whose economic, social and stress situations contribute to neglectful parental behavior.(8) Children should have the right to adequate nutrition, housing, medical services, education and other conditions and opportunities to develop in a normal and healthy manner. Society has the responsibility for enabling parents to assure their children proper care. The causes of child neglect usually are so interrelated with social deprivation and community neglect that it is our view that questions of parental versus community responsibility for child neglect, enforceable by law, should be handled under separate legal proceedings, i.e., neglect proceedings.(9)

Some of the issues involved in the question of how to deal with neglect, emotional abuse/mental injury in relation to physical abuse are as follows:

- *Existing neglect reporting statutes are sufficiently vague so as to allow for the inclusion of emotional abuse and mental injury.* Many states' statutes do not specifically mention, for example, emotional neglect but courts have been willing to intervene when a child is found, on the basis of vague criteria, to be emotionally injured or neglected.
- *Most states do not define emotional abuse or mental injury.* Interpretation of these terms is left open to child welfare agencies, probation, hospital or medical facilities, etc.*
- *Existing legislation and current trends towards expansion statutes to include emotional neglect or abuse tend to focus on parental behavior rather than on the emotional conditions of the child.* The types of vaguely defined conduct justifying intervention, for example, 'inadequate' parental affection, open up unlimited possibilities for casefinding and legal action.
- *Most existing and proposed legislation fails to provide specific guidelines which indicate the types of harm to the child that warrant state intervention.* If emotional damage is to be the basis for intervention, laws must be drafted that specifically limit interpretation and are consistent with the extremely limited available knowledge and research about the causes and nature of psychological or emotional harm to the child. Michael Wald, for example, has proposed that intervention be authorized only when emotional damage is "evidenced by severe anxiety, depression or withdrawal, or untoward agressive behavior or hostility towards others."(10) Even Wald's admirable attempt at a workable definition, however, opens up potentially conflicting and damaging interpretations by mental health professionals and judicial decision-makers.
- *Where removal based on emotional neglect is contemplated, the decision is often based on questionable predictions and speculations.* A judge would have to predict the probable impact of probable future behavior of the parent if the child remains in the home, as compared with the probable or possible beneficial consequences and risks of placement, including the emotional impact on child and parent of short or long-term separation.
- *The value-laden and vague nature of the definition of emotional neglect and mental injury lends itself to discriminatory application to minority racial and ethnic groups.* Since most helping professionals are white and middle-class, there is the ever present risk of misapplication of these social norms to the lifestyle and cultural differences of lower income minorities, especially in terms of what constitutes "proper parenting."

By recommending a narrowed definition of child abuse, we are not underestimating the potential seriousness of different types of neglect as a cause of varying degrees of damage to children.

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*In its Model Child Protective Services Act, OCD has attempted to define the concept of mental injury as follows: "Mental injury includes a state of substantially diminished psychological or intellectual functioning in relation to, but not limited to, such factors: failure to thrive, ability to think and reason; control of aggressive or self-destructive impulses; acting out or misbehavior, including incorrigibility, ungovernability, or habitual truancy; provided, however, that such injury must be clearly attributable to the unwillingness or viability of the parent or other person responsible for the child's welfare to exercise a minimum degree of care toward the child."

Some of the research literature does indicate that children can suffer at a vulnerable age from deprivations and distorted parent-child relationships that may impair normal growth, contribute to mental retardation and emotional disturbance, and limit their capability of becoming self-sufficient adults.(11) However, the purpose of narrowing the definition of abuse is to focus currently limited resources for vulnerable children where the problem is more readily diagnosable.(12) This focus of the model system does not preclude attention to neglect cases under existing neglect statutory jurisdiction, including failure to thrive, abused children who escape visible injuries, children with extensive injuries that do not in themselves result from abuse, and so forth.

2. *Inclusion or exclusion of sexual abuse.* "The paucity of information regarding the incidence of sex crimes against children and the absence of data assessing the impact and effect of the sexual victimization on the child victim's emotional health result in a general failure to mount a coordinated attack on this national problem." This statement, made by Vincent De Francis, Director of the American Humane Association (AHA), Children's Division(13) reflects the frustration of many professionals in dealing with the problem of sexual abuse of children. Actual data pertaining to present-day incidence of sexual abuse in the United States can only be estimated, as it is not specifically mentioned in the neglect statutes of most states.(14)

Not only is there variance in definition, but also in reporting and treatment practices.(15) Although, in general, the courts do intervene in identified sexual abuse cases, a great majority of incidents, especially those involving family members, may never be recognized or brought to the attention of 'helping' or other agency professionals and, ultimately, the courts. In a recent issue of *Children Today*, Suzanne Sgroi noted that "recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition exists" and that sexual abuse of children may well be "too dirty" or "too close to home" to become a national issue.(16) Ms. Sgroi goes on to say that "with the exception of congenital syphilis and gonococcal eye infection in newborns. . .all too few health professionals are trained to look for . . .gonorrhea infections in young children," and suggests that postulated modes of transmission of venereal disease to children via clothing, bedsheets, etc. within the family circle be discarded as they have been long ago in relation to adults.(17)

The public perception of sexual abuse concerns itself only with the most bizarre examples of the phenomenon (e.g., the stereotypic pervert lurking around the back of the schoolyard), making it almost impossible to grapple with the problem on a realistic level. Child molesters, therefore, have been singled out, on premises that may well be misleading, as objects of special legal and psychiatric concern.(18) The phenomenon of underreporting of adult-child sexual acts must be seen from the perspective that many such cases of abuse represent long periods of chronic activity through which the child may maintain a genuine overall affection for the perpetrator, and may be genuinely unable to perceive these acts as anything more than "unusual."(19) A three-year study by the American Humane Association (AHA) of sexual abuse in New York City revealed that 75 percent of the offenders were known to the child and that roughly one third of the children in this study were said to play "participant roles" in the molestation.(20) Although it is hard to judge "consent to participate" in sexual acts by very young children, it would seem logical to assume that most children would be more passively accepting of such a "special" relationship if overtures are made by a family member or close friend.(21)

Another factor in the underreporting of sexual abuse may be that, according to several studies, it has a direct correlation with an otherwise abusive/neglectful environment, and is itself symptomatic of family dysfunction.(22) Eleven percent of the families of child victims in the cited AHA study were abusive; and 79 percent were neglectful, with "emotional neglect" being the most common manifested type of neglect.(23) Michael Wald, a law professor at Stanford University, reports the finding that "the father often has. . .created an atmosphere of terror in the house. . .even though the home situation [itself] might not justify intervention if there was no sexual abuse, the added problems caused by the charges of sexual abuse might justify singling out these families for special attention."(24)

Seemingly, the exposure of children to overly stressful conditions in the home would make them additionally vulnerable to victimization by adults outside the home.(25) Another possible conclusion is that a multi-problem home environment would add to the child's difficulty in communicating to the parents what transpired as well as diminishing the likelihood that the child's account would be received with understanding, believed, and acted upon. Parents may be overwhelmed with guilt and too ashamed to report the incident; or they may project their guilt onto the child in the form of blame and verbal abuse.(26) Moreover, although the term sexual abuse clearly includes incestuous intercourse, less specific activity within the family may be hard to distinguish from more "normal" displays of simple affection.(27)

The foregoing discussion of what is known and not known about appropriate societal intervention in various forms of intra family sexual abuse leads us to exclude it from child abuse jurisdiction except in those instances where the sexual activity between a parent or person responsible for a child and the child results in medically diagnoseable injury. This position does not imply that the potentially negative impact of incest is limited to whatever physical injury may result from the sexual activity. Rather our position essentially concurs with Professor Wald's conclusion that "despite an abundance of theoretical material about the harm of sexual activity within the family, there are very few studies demonstrating the negative impact of sexual 'abuse,' [so that] any intervention [requiring] the child to tell his or her story to the police, welfare workers, and court may cause more trauma than parental behavior. . .There is little evidence about the efficacy of treatment programs following intervention that might justify this added trauma."(28)

Traditionally, the responsibility for treatment of incestuous families has been relegated to a community's protective service agency due to this agency's willingness to treat, even where there may be resistance or . . .hostility to treatment.(29)

In view of the lack of evidence pertaining to the efficacy of casework treatment of incest and the prevalent overloading of protective services caseworkers, the current role of health and mental health service agencies in this problem area should be reexamined with a view towards improving early identification and prevention activities. In this regard, school personnel should be closely involved in cooperative planning.

3. *Parental fault.* Child abuse evokes strong and angry responses from society, especially in response to the most severe cases of abuse—burning, mutilations, etc. The available research literature indicates that child abuse has complex and multiple causes which we need to learn a great deal more about from high quality research studies in order to separate myth from fact. In our literature review summary and, more extensively, in Appendix I, a variety of study and research findings are reported which suggest, at the very least, that a legal process aimed at determining parental fault in child abuse cases perhaps reflects an excessively rigid preoccupation with legalisms.

If we take the existing psychiatric and social work literature at all seriously, as preliminary research findings which require a considerable amount of additional substantiation, at the same time we should not conduct the legal process as though these findings did not exist at all. In other words, parents involved in child abuse at least should be given the benefit of the doubt that, for psychological reasons, they may be unable to deal with their angry feelings and to protect the child from them without appropriate services and treatment.(30) Our society and its laws hold parents responsible for protecting their offspring from harm. However, the purpose of the legal system in determining parental responsibility for a child's injury can be either *punitive* or *preventative*. A punitive purpose for state intervention in the case of an injured child involves determining parental *intention* and, thereby, fault in order to apply sanctions to the parent. The primary sanction available in civil court proceedings is child removal and placement. A preventative purpose for state intervention involves determining the parent's *responsibility* for the child's injury in order to ascertain future risk to the child or other siblings and the parent's capacity and resources for future protection of the child or other siblings. The primary decision of the civil court remains the same (i.e., to place or not to place) but the focus of court proceedings changes to one of examining the range of available alternatives in terms of their possible benefits and detrimental effects for parental capacity to protect the child.(31)

C. Overview of Model System Design and Operation

Professional and public awareness of physical child abuse problems in each community has to be increased by intelligent and sensitive use of the media supplemented by dissemination of factual literature. Public information and education should downplay sensationalism and should stress: what is known about the medical and social nature of the problem; the local resources available to persons in stressful situations who need or want to seek help; and also an *honest* depiction, in terms of possible benefits and legal consequences, of how the local system works to handle cases of injured children who may have been abused. Formation of a community-wide citizens' committee around the problem, which includes parents who have experienced child abuse problems (e.g., Parents Anonymous members), would be an excellent vehicle for developing the public information and education program as well as coordinating and monitoring efforts to implement the model system.

We've assumed that a system for handling child abuse which is non-punitive, immediately responsive to the problem situation, non-discriminatory to the extent possible, and safeguards the rights and self-respect of the persons involved will encourage the most reports of suspected abuse and self-referrals.

To foster a non-punitive system, we propose to: handle child abuse only under civil statutes, recognizing that prosecution of abuse cases under criminal statutes (e.g., assault and battery) will continue at the discretion of local law enforcement officials; reduce the number of petitions filed in civil court to those in which custody and placement decisions are essential; reduce the necessity for and the length of time in placement by provision of emergency services; limit the investigation process to criminal cases and limit use of the criminal process, wherever possible, to homicides and perhaps heinous cases of abuse; limit police and protective service involvement in the investigation/verification process and focus initial intervention (outside of medical facilities) on public health agencies or paramedical personnel.

To create an immediately responsive system, we propose to: encourage development of 24-hour, seven days a week telephone service, probably as part of a larger emergency-oriented communication system, linked to the local public health unit or police if the former is not available; encourage the development of emergency caretaker, homemaker and shelter resources which are available in connection with responses to reports of abuse or self-referrals; concentrate diagnostic resources (e.g., public health nurses and hospital-based medical personnel) at the "front-end" of the system, to perform the medical verification and treatment functions (as necessary, in conjunction with emergency services provided or coordinated by protective services); and concentrate protective service resources on handling cases under informal or formal court dispositions (possibly in collaboration with hospital-based multi-disciplinary teams).

To foster a non-discriminatory system which protects legal and human rights, we propose to: set strict limits on evidence and information gathering prior to assumption of court jurisdiction in civil cases; encourage the use of fair warnings to parents or other persons responsible for the care of injured children with respect to the possible benefits and risks of intervention by all classes of helpers, diagnosticians and treatment personnel; make legal representation available to parents and child in connection with custody and all subsequent court proceedings; make a guardian ad litem-lawyer a member of the hospital-based diagnostic team and another appointed for the child in connection with possible court proceedings; limit and establish strict safeguards for the case information collected, retained, used and disseminated in connection with pre-court diagnostic, verification and custody decision-making; focus the decision to refer a suspected abuse case for a civil court proceeding, whenever possible in a specialized, hospital-based medical diagnostic process, and place the exclusive authority for filing a petition with the counsel for the local jurisdiction (e.g., city/county attorney or corporation counsel); and emphasize on-going training on all aspects of child abuse for law enforcement officers, probation officers, judges and referees, attorneys for the locality and the state.

The pattern of reports and/or referrals for court processing changes from existing practices under the proposed model system as a result of the following assumptions (summarized in Chart I): narrowing of the definition of abuse; change in the role of law enforcement and protective service agencies; change in recipient of reports; public information and education program combined with 24 hour hotline; mandatory hospital examination prior to filing of a petition; and near elimination of criminal court prosecution.

D. Hypothetical Scenario: Handling A Suspected Child Abuse Case in the Model System

The following hypothetical scenario illustrates how a case of suspected child abuse might be identified and handled within the proposed model

Chart I. Assumptions Regarding the Resulting Pattern of Suspected Child Abuse Reports/Referrals

Source of Reports/Referrals	*Change in Reports/Referrals*		*Rationale for Change*
	Numerical Change	*Percentage Change*	
Private Physicians	No significant increase	Decline	Continued reluctance to report patients and become involved in legal process, especially with middle class clients; police role minimized, criminal court minimized, but civil court processing increases; improvement of court organization and process an important but not an overriding contingency.
Protective Services/Social Services	Significant decrease	Significant decrease	Definition of abuse narrowed; investigative role eliminated and service role expanded; no longer official recipient of reports; emergency cases taken to hospital for further examination.
Law Enforcement	Significant decrease	Significant decrease	Definition of abuse narrowed; investigative role limited to potential criminal cases, and severe battering under strict standards for search and other investigation procedures; emergency cases taken to hospital for further examination; no longer official recipient of reports.
Schools	Significant increase	Significant increase	Information and education program; availability of ICEU for examination of children in school and to train school nurses for abuse identification; elimination of police as official recipients of reports; mandatory hospital servicing prior to legal action.
Other Professional Sources	Possible increase	Possible decrease	Only a small number and percentage of reports come from other professional sources; the number may increase with an improved system but, in relation to the ICEU and schools, the percentage will decline.
Individuals	Significant increase	Significant increase	Public information and education program; well-publicized 24-hour 7-day hotline number; rapid follow-up by ICEU, usually without police or public welfare involvement.

system. The number of variables in the case situation have been reduced to a minimum; likewise, the scope of factual information has been simplified. The scenario does not include many of the complexities of case history that are so familiar to protective service workers, hospital trauma staff, police investigators, and others involved in handling child abuse cases. Essentially, the scenario summarizes how decisions might be made within the framework of the model system. A detailed guide for the model system decision-making is presented in Chapter IX of Part 3, in which we compare existing and proposed model child abuse handling systems.

At police district headquarters in a metropolitan area, a call is received at 6:30 pm concerning a domestic disturbance. A patrol car is dispatched to the scene. The two policemen drive to a neighborhood of small tract houses on the outskirts of the city.

At the front door, the patrolmen hear a baby crying intermixed with loud voices. The doorbell is rung several times before the door is opened. The officers note the name on the mailbox. A man stands at the door, a woman behind him. "Good evening, Mr. and Mrs. B.? May we come in? There's been a complaint . . ."

The man walks away from the door without directly acknowledging the officer's request. As the police enter the small hallway, the man directs them to the living room off the hallway. The police officers survey the living room. Nothing is turned over or appears to be broken. The man has regained his composure. "What can I do for you, officers?" the man asks. "My wife and I were just having a disagreement. It doesn't mean much."

From somewhere in the back of the house, the child still is crying violently.

One of the officers says, "We just want to be sure everything is o.k. here. We had a complaint about too much noise. Is something wrong with the baby?" The woman answers, hesitantly, "No, he just cries a lot", while the man interjects, "Yes, he's had a slight cough . . .", and to his wife, "I'll handle this."

The officer says to the woman, "You can look after the baby if you want to." As the woman leaves the room the officer suggests to the man that, if the child is sick, he might need to see a doctor. The man flushes with anger. "We'll look after the baby."

The officer begins to explain that they received a complaint about a lot of noise and that they should "keep it down".

By this time the woman has returned to the living room holding the baby. His crying has subsided a little. The child looks to be about a year old. The mother has him wrapped in a blanket and she stands holding the child in the middle of the room away from her husband and the policemen.

While his mother pats him on the back, part of the blanket falls away and one of the officers notices large bruises on the child's left forearm. The officer says, "That's a pretty bad bruise he's got". The mother realizes the blanket has slipped off and tries to cover the bruise with it again. The officer walks over to the mother and asks if she has had the bruise looked into. The husband now has joined his wife and replies that it isn't necessary because the child is always falling down and hurting himself. The officer is suspicious of this explanation. The child seems just barely old enough to walk. He asks to take a look at the arm again. The mother steps back with the child. The husband says, "Look, I thought you came here to tell us about the noise." The officer says, "That's right, but I think you ought to let us see the child. If we have to, we can see about getting a court order to have a doctor look at him."

The woman looks anxiously at her husband. He nods his head. The officer removes the blanket and looks at the baby's arm. He asks the mother to lift his pajama top. There are more bruises on the right side of the boy's back.

One officer says firmly but gently that the boy looks like he needs medical attention and that he'd like to call a nurse to come over and examine him. The parents answer this request with silence. The officer places a call to the ICEU (Injured Child Examination Unit). The other officer returns to the car and waits there.

Within 20 minutes a public health nurse arrives. She holds the baby for a few minutes and talks to Mrs. B. about the child. Mrs. B is still visibly upset but a little more relaxed. While examining the child, the nurse observes that there is a problem straightening the child's left arm. The baby cries out. Moving the arm is obviously painful to the child. The nurse concludes that an x-ray is needed to determine the nature of the injury.

She tells this to both parents. The mother, apparently relieved, dresses the baby. The nurse offers to drive the parents and child to the hospital. As the mother, child, and nurse walk out to the nurse's car, the husband says he'll meet them later. The police leave at the same time. They call in a report to the station house from the patrol car.

The child is brought to the emergency room of the city's general hospital, which is the CIMC (Child Injury Medical Center) containing a trauma unit. The appropriate hospital intake staff person fills out the necessary admission form, including the child's medical history. Later the public health nurse liaison will be notified to check with the public health agency on whether the child or his family has had health problems in the past. The public health agency, however, has no record of service to the family. There is also no record *on file of prior admissions for the child at the hospital.*

The mother indicates there is no family doctor. The name of the hospital where the child was born is noted. Later a trauma team physician will contact that hospital's chief pediatrician to determine if there is any medical history of the child there. That hospital however has no record of any post-natal care.

While the admission forms are being completed, the physician on duty begins the examination of the child. He requests a complete skeletal survey for signs of trauma. The x-rays developed reveal a spiral fracture of the left arm and a resolving fracture in the right forearm. A trauma team physician, on-call 24 hours a day, and a team pediatrician are called. With direction from the pediatrician, a technician takes photographs of the child's bruises. The left arm is then placed in a cast. The CIMC trauma team coordinator consults with the team physician and pediatrician. A decision is made to hospitalize the child, at least for several days, to monitor the healing of the arm and bruises, and evaluate further when the resolving fracture in the right arm may have occurred and if it will be self-correcting.

The child's injuries are clearly suspicious to the team coordinator, physician and pediatrician, so they also decide that special consent from the mother should be sought.

The pediatrician goes out to the mother who is in the waiting room. He takes her aside and explains to her that he will be responsible for the child's medical care. He introduces himself to the mother as a staff pediatrician who would like to talk about the child's injuries. He explains the x-ray findings. He tells her that the left arm has been placed in a cast, and that the child is sleeping and appears to be doing fine. He further explains that the child should be kept in the hospital for a few days for treatment and observation. He adds, "I think I should tell you that it may also be necessary to look further into how your boy's injuries occurred."

The mother, feeling upset and threatened, is defensive and starts to deny any knowledge of the injuries. But the pediatrician interrupts her and explains there's no need to talk about it now, and that there will be a staff meeting in the morning to discuss the matter and that she's welcome to attend. He then tells her that he would like her permission to keep the child in the hospital for a few days. He shows her a consent form and explains its purpose.

Mrs. B. signs the consent form which allows the hospital to retain the child for forty-eight hours. The form specifies that any extension of the treatment period is subject to parental approval. This is also explained to the mother. She asks if she can visit the child and is assured that she can come during any regular visiting hours. The child is admitted as an in-patient and sent to the pediatric ward. Mrs. B. is driven back to her home by the ICEU public health nurse, who has remained with her at the hospital during the initial examination.

The next morning, the team coordinator and a pediatric nurse call the Child Abuse Information File number at the district court. There is no record of the family in the File. This is noted on the case record.

Mrs. B. is not at the hospital that morning for the staff meeting. At the staff meeting, the CIMC trauma team members who have had contact with the case present diagnostic information and discuss whether, in view of the nature of the injuries and the medical history offered, the child's injuries were inflicted. There's a consensus that the injuries probably are not accidental; but the trauma team is uncertain whether the child is at risk at home.

The team decides that at the very least, the child should remain in the hospital for further observation and that there is enough question about the risk in Jimmy's home environment to warrant further investigation. The team concludes to talk further with the parents before deciding whether a referral is appropriate.

That afternoon, at 2:30 pm, the regular visiting hour for the pediatric ward, Mr. and Mrs. B. return to the hospital. They talk briefly to the nurse attending the child.

The nurse first explains that the child's arm is going to be in a cast for a while. She also tells the mother, "We've put him on a special diet. He's underweight for his age."

The mother replies that he was never a good eater and never liked any of the baby foods she tried to feed him.

"We have a nutritionist on our staff," the nurse replies. "You might get some suggestions from her. Also, Dr. R. the pediatrician would like to talk with you and your husband if possible, before you leave."

Mr. and Mrs. B. meet with the pediatrician at the end of the visiting hour. The pediatrician explains the nature of the team's concern. "We would like to know more about how your boy was hurt. It's a serious matter. But first I should tell you that if it appears someone hurt the child, I might be called on later in court to testify about our conversation. So you have a right not to discuss the matter with us. You might want to consult an attorney before we talk any further."

Mr. and Mrs. B. are quite shocked to learn that there might be court action. Mr. B. protests that there must be a misunderstanding. He refuses to talk about the situation and both leave the hospital.

At the evening trauma team meeting the child's progress and the day's developments are discussed. There's general agreement on the need for referring the case to the city attorney. The medical diagnosis is completed and the trauma team has completed all permissable efforts to develop additional information.

The team coordinator prepares a preliminary report for the city attorney, detailing the nature of the injuries and suggesting a pre-petition investigation. The report is accompanied by a request for the filing of a motion for a temporary protective restraining order (TPRO) to retain custody of the child for an additional 48 hours, if the parents do not renew their consent. The report will be referred to the county/city attorney the following morning.

After reviewing the report forwarded by the CIMC the next morning, the City Attorney arranges to meet with the team coordinator and the team pediatrician to discuss the medical findings.

Meanwhile, Mrs. B. has returned to the hospital to visit her child. The pediatrician meets with her. He talks to her about the prior evening's staff meeting. He tells her that the hospital staff feels that it's necessary to inform the city attorney about the child's injuries. "There may have to be a court hearing. The city attorney and the court may want to find out more about the reasons why he was hurt. If there is a hearing, you'll have an attorney appointed to represent you and your husband," he continues. "Your child will have an attorney, too. I don't want these things to happen if at all possible, but I don't control that. We have to look out for your child's needs when he's ready to leave the hospital."

They talk a little about the consequences of what the doctor has just said. The mother then asks when her child can come home. The pediatrician replies: "We'd like to keep him in the hospital for another few days, until this gets resolved. In any case he probably should stay a few more days so that we can keep an eye on those two fractures and be sure they are going to heal right."

He explains to her that the hospital would need further consent and that she has a right to refuse. After some additional discussion, she agrees to leave the child in the hospital and signs a new consent for which gives the hospital authority to hold the child an additional 48 hours.

In the afternoon the City Attorney meets with the team coordinator and pediatrician. The City Attorney concurs that the findings of the medical examinations confirm that the boy's injuries probably were not accidental. He informs the team that the report would provide a sufficient basis for filing a petition. The team members express their concern that more should be found out about the family situation before concluding that filing a petition would be the best thing to do. They ask the City Attorney about the desirability of a pre-petition investigation.

The City Attorney explains that a pre-petition investigation is permissable to develop additional facts necessary to provide a probable cause basis for the petition. "Since there already is sufficient probable cause for a petition," he says, "a pre-petition investigation would be unnecessary." He concludes, "We have to base our decision on what information we already have."

The two team members and the City Attorney then review the available information. The child's medical history is sketchy; neither public health nor the hospital where the child was born were able to add anything to the information the mother gave at the hospital. The check of the CAIF was negative. The parents have so far maintained their right not to discuss the child's injuries. There is an indication in the report by the police of their visit to the house that the explanation given by the parents about the baby's bruise may have been untrue. But the City Attorney cautions, "not too much reliance should be placed on that since it doesn't appear that any warnings of rights were given to the parents at that time."

The discussion then turns to the child's injuries. "The decision to file a petition really hinges on the fact that, apart from the fracture found in X-rays of the left arm," states the City Attorney, "there was a resolving fracture of the right arm. We don't know the cause of this other fracture," he continues, "it clearly occurred at an earlier *point in time than the bruises and the fracture to the left arm." The CIMC staff and the City Attorney review some of the other knowns and unknowns in the case. The medical history does not indicate that a doctor was seen about this earlier fracture or that any treatment was sought. "The sequence of injuries indicates that the child may be under a continuing risk in the home," suggests Dr. R.*

The City Attorney will prepare the petition and a motion for an interim custody order. He explains to the two CIMC team members that since the mother earlier consented to an additional 48 hour custody period, he will file the petition and ask that the hearing on the motion be scheduled in two days (i.e., the beginning of the fourth day of the child's stay in the hospital). "In that way I can give adequate notice to the parents," he says.

The petition and motion are prepared and filed by the end of the afternoon. The City Attorney sends copies of each and a notice of the hearing by certified mail. The next morning, he follows this up with a phone call to the parents and informs them about the hearing. Meanwhile, the court clerk issues a summons and notifies the family court probation officer to carry out the service of process.

On the day of the hearing the parents are present in court. Since they cannot afford a lawyer, in accordance with court policy for legal representation in child abuse cases, the judge appoints a lawyer for the parents from the public defender's office; counsel for the child from the legal services program; and a guardian ad litem from a volunteer list of attorneys and qualified laymen.

The hearing is adjourned briefly until the public defender's office is notified and a lawyer for the parents arrives.

Prior to these decisions, the court's clerk, upon receiving the petition, had notified the legal services program and contacted persons from the list for guardians ad litem. Thus, the lawyer for the child and the guardian ad litem were already in court to accept their appointments.

In a short while, the public defender arrives and meets briefly with the parents. Both the parents' attorney and the child's require time to prepare for the hearing on interim custody. They request a continuance. The judge is willing to grant the continuance but, first, he has to decide the question of the child's custody. The second forty-eight hour hospital custody period, consented to by the parents, is due to expire. The attorneys inform the judge that two days is sufficient for them to prepare for the interim custody hearing.

There is another adjournment while the parents talk briefly with their lawyer. Their lawyer suggests, "It might be best for you to agree to allow the child to remain in the hospital for two more days until we can find out more about the situation." The parents agree.

The public defender then discusses the arrangement with the City Attorney and the child's lawyer and guardian. All the parties agree to allow the child to remain in the hospital until the next hearing date. The judge agrees with the arrangement and enters it as an order. "Perhaps you can all reach some agreement on the child's custody pending the adjudication hearing," the judge suggests.

When the hearing is over, the parents and their attorney go back to his office. After some initial hesitency, both begin to talk frankly with the lawyer. The father admits that he didn't mean to hurt the child but that he lost his temper. They talk about their problems and the problem with the child. Both express a strong desire to have the child returned home.

When the parents leave, the lawyer contacts the City Attorney who's willing to discuss the CIMC Trauma report. "I'd be willing to recommend that the child be returned home at the next hearing," he says. "As long as I have some guarantee that both he and the family get some help. We filed the petition mainly because we wanted to be sure the child would be safe."

Over the next day and a half, the City Attorney, the child's lawyer and guardian and the parents' lawyer are in close contact. A meeting is quickly arranged between the lawyers, the CIMC trauma team and a protective services representative. Elements of a treatment and service plan are discussed.

The parents' lawyer has been keeping the parents advised of developments. A tentative plan is outlined. The lawyer contacts the parents and discusses the details. They indicate a willingness to attend a counselling session with a family service agency, arranged by protective service and to cooperate with the recommendations that develop from that session. They are also willing to accept daily visits from a home-care worker pending adjudication.

When the interim custody hearing is reconvened, the court is informed that the parties have reached an agreement to return the child home *pending adjudication. The service plan to be followed pending adjudication is submitted for court approval.*

The court approves the interim plan and orders the child returned home. The court schedules an adjudication hearing in 10 days. A preliminary pre-trial conference is scheduled in two days.

At the preliminary pre-trial conference, the judge inquires whether there is the possibility of a settlement. The lawyers indicate that there is a good possibility. They discuss their respective discovery needs and agree to try and complete discovery within a week. The judge schedules a final pre-trial conference on the day before the hearing. "If additional time is needed," the judge remarks, "the adjudication hearing can be continued."

While the discovery process is going on, the parents have their first family counselling session. They express their willingness to continue counselling sessions. "The homecare worker is helping a lot, too," says Mrs. B.

During this time, the terms of a possible consent agreement are explored and eventually agreed to by all the parties.

On the date for the hearing, the parties appear with counsel. The parents enter an admission to the allegations of the petition. The City Attorney and the attorney for the child jointly recommend for disposition a six-month supervision period and continuation of the interim plan. The court accepts the admission and orders supervision by the child protective services agency. Monthly reports on progress of the case are to be submitted to the court, the attorneys for the parties, and the appointed guardian ad litem.

E. Additional Key Issues of Model System Design and Operation

1. *Mandatory versus permissive reporting, penalties for failure to report, and abrogation of privileged communication.* Ignorance of the law and of child protective procedures may contribute to inadequate reporting of suspected child abuse. A major reason for professional underreporting, however, is lack of confidence in the child protective law enforcement and judicial system that handles suspected abuse cases after a report is made.(32) For similar reasons, families in stress and need, whose children are particularly vulnerable to maltreatment and mishandling by "helping" services and the legal system, frequently do not seek help on their own.(33) The more that professionals and lay persons know about the possible adverse consequences of reporting, the more they tend to be reluctant to use reporting mechanisms, even to provide protection to maltreated children.(34)

The strategy for the proposed model system aims at avoiding the pitfall of resorting to coercive laws in order to force compliance and cooperation, especially from professionals, with a child abuse intervention system that has reporting laws, criminal penalties for failure to report, and abrogation of privileged communication, that each and collectively, aim to coerce responsiveness to a child protection system that often functions inadequately. Consequently, at this time, we advocate improvement of services provided by the child protection system as the more effective method of increasing reporting.

a. *Mandatory versus permissive reporting.* All states currently require, under penalty of law, certain classes of professionals to report suspected abuse.(35) The laws of three-quarters of the states mandate reports of neglect.(36) The Federal Child Abuse Prevention and Treatment Act (P.L. 93-247) provides for mandatory reporting of child neglect. Under existing laws and systems of child abuse and neglect intervention, trying to distinguish between abuse and neglect probably serves no useful purpose. Priorities for the allocation and organization of scarce resources currently are not set by differentiating between abuse and neglect.

The question at issue is *should* they be when it can be argued that neglect may cause harm as serious as abuse and even death; therefore, both abuse and neglect should merit equal priority.(37) The rationale for the model system doesn't attempt to resolve this issue. Rather, it argues that physically abused children, as defined above, in all cases should be handled as *medical* emergencies requiring immediate medical treatment and examination. No doubt there are neglect cases, e.g., failure to thrive, which are equally serious in terms of actual or potential damage to the child. However, the nature of most neglect cases probably does not warrant immediate medical attention. Thus, essentially we are arguing for a different purpose and process for reports of abuse, namely: *to trigger immediate medical examination treatment and protection on the assumption of possible imminent permanent harm.* In other words, under the proposed model system, differentiating between abuse and neglect would establish and justify service priorities for community service systems already overburdened with maltreated children.

In order to underscore the priority for abuse cases, it would seem reasonable that penalties for non-reporting of suspected abuse cases should at least be equal to, if not exceed, those for neglect cases. However, there is no evidence that penalties for non-reporting have induced increased reporting. In fact, persons not required to report make the majority of reports of maltreated children, and private physicians as a primary class of mandated reporters make the fewest reports.(38) In practice, all reports of child abuse from any source should be equally important, as should be failure to report from any source. It is our judgment that penalties for failure to report add excessive legalism to child abuse intervention at a point in the system where it is least likely to be productive.(39)

To the extent that mandatory reporting is aimed at inducing more reports from physicians, its premises have proven to be unrealistic. One fundamental problem of physician underreporting derives in large measure from the lack of a universal maternal and child health program in the United States. In lieu of such an across-the-board case-finding system, we have to rely excessively on unworkable reporting laws that tend to result in discriminatory case-finding—usually after a child has already been damaged.

b. *Penalties for failure to report.* Criminal and civil liability for failure to report child abuse presupposes a statutory mandate to report. A primary reason for proposing to eliminate mandatory reporting for all classes of citizens and professionals, except physicians, is the virtual impossibility of proving "knowing failure" on the part of those required to report. Under the '"knowing failure" or deliberate negligence standard, it must be proven that a mandated reporter (1) had reasonable cause to suspect child abuse, and (2) intentionally failed or neglected to fulfill these obligations. It is our judgment that the situations under which liability might arise and be proven are quite limited. Further, as pointed out above, there is no more than anecdotal evidence that penalties for failure to report increase the efficacy of reporting laws in encouraging reports. Indeed, as a hypothesis for designing a child abuse reporting law, it would seem more realistic to mandate states to develop and implement methods of educating professionals and the community as to reporting procedures, together with improvement of the system which addresses problems of child abuse. Physicians under the model system would be required to report. Nothing in the proposed system should be construed as protection against civil liability of physicians for damages resulting from their failure to report. Further, in the event that a physician is sued civilly as a consequence of filing a report of suspected child abuse, state resources should be made available for defense of the suit (e.g., the state attorney general's office) so that physicians will not be penalized financially as a result of fulfilling their legal obligations to the state. Any citizen reporting in good faith would be protected from civil and criminal liability as a result of the report.

c. *Abrogation of privileged communications.* Rules of evidence—of which the creation and abrogation of privileged communications are examples—are developed to govern the course of a hearing or trial and address themselves to what persons and matters can properly be brought before the trier of fact. A major reason generally offered for abrogation of professional-client privileges in child abuse matters is to permit the testimony of "helping" professionals (e.g., physicians, psychologists or psychiatrists, social workers) to be heard in a court of law. Existence or abrogation of various privileged communications (e.g., husband-wife, professional-client) exist under statutory authority and determine who may be compelled under penalty of contempt to testify, and to what matters any such persons may be compelled to testify. Under the Constitution, the Fifth Amendment privilege against self-incrimination also addresses itself to these same issues.

The creation of legally-recognized professional-client privilege (as distinct from privileged communications established only by professional canons of ethics) extends outside the courtroom to any revelation sought by the state, whether in a court of law or not. Thus, for example, any attempt by the executive (police) arm of the state to compel revelation of a communication recognized by statutory law as privileged is improper and will not be enforced by the judicial branch.

In relation to child abuse, every state now has some form of mandatory child abuse reporting law which requires, often under criminal penalty, a variety of professionals to report suspected incidents of child abuse. Where both a mandatory reporting law and a law recognizing privileged communications between professional and client exist, a conflict between the two laws arises.

Thus, for example, if a physician is mandated to report child abuse but cannot be compelled to reveal patient-physician communications, the question arises which law governs the situation in which a patient or patient's parent reveals an incident of abuse. The same dilemma holds true with psychoanalyst-patient communications and the like.(40) Under present laws, this question has been resolved by the determination that discovery of possible incidents of child abuse is more important than the protection of professional-client communications *in this area*. If a child abuse reporting law maintains all professional-client privileges while at the same time attempting to mandate certain professionals to report incidents of abuse, the effect of the former cancels out the latter. The force of the continuation of a legally recognized privilege, coupled with the general requirement of professional canons for confidentiality will, in the majority of cases, lead professionals to determine their duty to report according to the concept of confidentiality rather than the mandate to report. Further, it is likely that, should such a determination ever be challenged in a court, the choice of the professional would be upheld.

In accordance with the proposed model system's heavy reliance upon medical institutions and personnel for the detection and reporting of suspected child abuse, physician-client privilege will be abrogated in cases of suspected child abuse. No other professional-client privilege would be abrogated. This position accords with the generally recognized harm to "therapeutic" relationships occasioned by court involvement of helping professionals, and with an assumption that an independent psychological, social, or psychiatric evaluation can be performed by the court as necessary for disposition of the case. Medical testimony appears to be the most important evidence presented at trial in child abuse cases at present, and this form of testimony will continue to be available under the model system.

A separate set of considerations applies to the question of spouse-privilege. Members of the household are often the only witnesses to incidents of child abuse; their testimony thus may be crucial in a case. At the same time, spouses often are reluctant to testify against their spouse, and indeed such a courtroom betrayal of confidence may further damage a family already under stress. In order to allow testimony of a spouse when that testimony is willingly available, the proposed system would have spouse-privilege which runs to the party testifying. That is, a person who has been asked to testify against her/his spouse may consent or refuse to testify.

2. *Child abuse information and record systems.*

a. *Critique of central registers.* The national trend is to expand central registers of child protective cases; to keep track of prior reports and case progress; to provide decision-making information (e.g., assessment of risk of reinjury) to persons handling child abuse cases, including diagnosis and evaluation, for case management; to monitor follow-up on cases; to provide statistical data for research, planning and program development; to ascertain the "true" incidence of child abuse; to help measure system performance; and to encourage reporting.(41) The expansion of central registers is intended to increase the types of maltreatment cases handled as well as the scope of register functions.(42) Conceivably, the scope of reports and case monitoring would encompass hundreds of thousands and, over time, millions of cases handled by all types of service systems, law enforcement and courts, and medical facilities.

The information on abuse and maltreatment cases going into expanded central registers would include family social history data. Because of the difficulty of conclusively validating reports of abuse and maltreatment, it is proposed, for example, in the Model Child Protective Services Act, to include and retain any information that, in the judgment of protective service workers, might be useful at some time in the future in evaluating subsequent reports on a family.(43) Even where there is no evidence of physical injuries, or the injuries are satisfactorily explained, a "credible" report would be retained in the central register.(44) The information in all reports, unfounded or otherwise, would be retained for research or diagnoses purposes.(45)

Even though subjects of reports might have a right to access to the information in their reports, and the right to challenge their content in a hearing process, there are substantial dangers inherent in the development of such comprehensive and computerized central registers.* Central registers ultimately are intended to function as *child welfare information systems*, not simply as child abuse information systems.(46) In the proposed model system, we make a distinction between the two types of systems as to purpose, functions and safeguards.

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*Given the large number of subjects, reports and types of information in each report and cumulatively over time in each state system, and the need for rapid and efficient access, it is assumed that central registers will evolve as statewide computerized systems with the capabilities for inter-state link-ups and local terminals.

All 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands require by law that certain persons report incidents of child abuse, either orally or in written form, to the police department or to the department of social services.(47) After investigating the suspected abuse, in states where central registers exist, a standard report is supposed to be transmitted to it to be filed and cross-indexed. At least 46 states currently make provision, by law or administrative policy, for a central registry to forward reports under the state's mandatory reporting statute.(48) If there is a record in the register on the same child or parent, notification of the previous injury is supposed to be released to those persons and/or agencies mandated to receive reports.

After reviewing the literature on central registries, assessing the philosophies and roles of professionals involved in child abuse identification, and examining the type of data collected in relation to its intended multiple uses, we are unconvinced that the potential benefits of improving centralized and computerized registers outweighs the potential costs.(49) Furthermore, we have found no existing studies of the potential costs and benefits of central registers which would either justify their existence at all or their expansion.

Four of the key assumptions of a central register concept are discussed below, followed by the model system's proposal of a "Child Abuse Information File."

- *A central registry is needed to ascertain the "true" incidence of child abuse.* To date it has been impossible to determine the true incidence of child abuse.(50) The first problem is that definitions of child abuse under most state statutes encompass intentional or non-accidental infliction of physical injuries and also various types of child neglect, while some statutory definitions include emotional abuse and sexual abuse.(51) Verifying the incidence of intentionally inflicted physical injuries has proven difficult enough. Ascertaining the "true" incidence of inflicted injuries, as distinct from the reported and verified cases, may be an impossible statistical feat. The incidence of neglect and emotional abuse involves substantial definitional and diagnostic problems and it is even less likely that the "true" incidence of either one can be determined. Sexual abuse, which is reputed to be even more prevalent than physical abuse, also is likely to defy determination of its "true" incidence. Thus, except possibly for serious inflicted injuries, which pass through hospitals, it probably will be futile to design a data system to even approximate the "true" incidence of child abuse.(52)
- *A central registry is needed to supply "research" data on the characteristics of abusers and the victims of abuse, the outcomes of abuse, etc.* If we cannot even agree on what constitutes child abuse, on the definitions themselves (e.g., inclusion of neglect and emotional abuse), then the research function of central registers as a centralized storehouse of miscellaneous data on "founded" and "unfounded" reports is of questionable value. In fact, using the term "research" may be a misleading misnomer. In our literature review, we have not found one item which more than superficially addresses questions of design, organization and operation of central registries for policy-relevant research purposes, especially in light of the deficiencies of available data and data sources.
- *All previous reports of suspicious or unexplained injuries are useful to a physician examining an injured child.* The examining physician doesn't need all previous reports of suspected injuries to make a medical diagnosis. At least in some instances, the existing injuries should "speak for themselves," especially when the majority of serious injuries are inflicted on children 3 years of age or younger. Furthermore, the paucity of information in reports, especially for medical diagnosis purposes, and the incompleteness or possible unreliability of the diagnostic information, would tend to make physicians very reluctant to rely on them.

  In deciding to make a report, a physician knows that the reported patient may be subjected to the vagaries of the legal system, including possible child removal. In effect, asking physicians to report non-serious or "gray area" cases on the basis of central register data creates serious ethical problems for the physicians. Moreover, the physician's diagnosis—including use of central register data in the diagnostic process—would have to be substantiated in court. Thus, the practical usefulness of a central register for diagnostic purposes by private physicians is a questionable premise. Its utility for hospital physicians remains to be tested and proven.

- *The central registry should contain reports of suspected abuse cases.* There is no research evidence to support the contention that certain types of information on *suspected* cases is of value for research, medical diagnosis or tracking purposes. Many reports of child abuse are groundless, never validated, or fail to reach a judicial decision on the evidence. Relying on unverified information about suspected child abuse for research, program planning or diagnostic purposes, raises questions about the ethics, judgment and intentions of the professional involved.

An implicit recommendation of the model system is a moratorium on further development of central registers until their design and utilization has been further studied and tested on a pilot basis with very stringent requirements pertaining to protection of the privacy and confidentiality of family life. Any proposals for expanding the reporting requirements and record-keeping functions of central registers, especially centralized in statewide centers using computer facilities, is extremely premature in view of the unknown and unproven value of existing systems and the known potential hazards of centralized and computerized information systems which collect and disseminate identifying information.

Furthermore, depending upon the basic premises for designing such systems, a strong case can be made for central registers being duplicative of existing record-keeping systems, specifically court record systems, and excessively costly in relation to the amount of resources available for child protection services. We would recommend assigning secondary priority to the development of costly statewide information systems until the state-of-the-art and the quality of protective resources for endangered children has been significantly advanced.

b. *Model system's "child abuse information file".* One of the greatest dangers to the privacy and rights of parents and children involved in child abuse cases is the misuse of information collected pursuant to reports of suspected child abuse (and other forms of maltreatment). The problem is one of identifying information, collected from a variety of sources, retained and accumulated in a central repository for long periods of time, with a multiplicity of possible users, without adequate safeguards pertaining to verification, access and dissemination, and uses in tracking, monitoring or surveillance of either parents or children.

Under the model system, a "founded case" is only one in which a petition has been filed in civil court or a charge filed in criminal court which results in an adjudication and disposition (formal or informal). Therefore, the location of all records on "founded" cases is in a courthouse record system. On the other hand, all cases which are dismissed in civil or criminal court would be automatically expunged from the court's "Child Abuse Information File."

The purpose of access to this information is to prevent reinjury to a child suspected of having an inflicted injury. The persons who need access to this information are: police officers contemplating criminal charges; ICEU staff examining a suspected abuse case who may have doubts about whether the injury qualifies for a hospital medical examination; CIMC trauma unit staff who may have doubts about the necessity for filing a petition *after* a medical examination of the child; counsel for the local jurisdiction who may have doubts about the necessity of filing a petition; and the court itself.

After court action is completed, all of the parties indicated above would be informed of the outcome of the case for their own records so that the case can be marked as "founded" or "unfounded." If the case is "founded," all the parties indicated above would have access, with strict safeguards to confidentiality, to all court records on the case in the event that the same child or a sibling is reported or appears as a suspected abuse case. The model system's proposal to utilize court records and record management systems in lieu of a central register is made with full knowledge of the current inadequacies of these systems. However, the federal government in particular, through the Law Enforcement Assistance Administration, and state and county or other local governments are expending large sums of money to upgrade court records management. The model system proposes that, as part of this overall effort, courts give priority to establishing a "Child Abuse Information File" (or records management subsystem), with explicit policies for their storage, retrievability, access, security and confidentiality, retention, sealing and destruction.

In many courts, this process of overall development of a quality records management system is well underway. The presiding or administrative judge is responsible for issuing policies and procedures consistent with statutes and with state court system rules and procedures, for all aspects of court records management. A particular court official usually is designated to have responsibility for the administration of court record policies and systems. In larger juvenile or family courts, computerization or microfilming of records has proven necessary. In most large courts, microfilming of the "Child Abuse Information File" would be adequate.

The development, implementation and monitoring of a plan for information and records pertaining to child abuse requires specific standards, policies, mechanisms and procedures. These are set forth below both to provide guidance for state and local model system designs and to focus attention on the operational issues involved.*

(1) *Child abuse information and records committee.* Under its reporting statute, each state should establish a committee, within or outside of the court system, or a sub-committee of an appropriate state committee, concerned with issues of privacy and confidentiality of records, which should have the authority to examine and evaluate records and information issues pertaining to children and parents subject to the state's abuse (and neglect) statute(s) and the right to conduct such inquiries and investigations as it deems necessary to make recommendations concerning privacy, records, and information practices and policies pertaining to the handling of child abuse cases. The committee or sub-committee should have authority to approve and disapprove proposals to establish "Child Abuse Information Files." The committee should have the authority to approve and disapprove rules and regulations of state and local, public and private agencies pursuant to the collection, retention and dissemination of information pertaining to children and other persons involved in suspected or confirmed cases of child abuse. Copies of these rules and regulations should be made available to the public, to consumers of child abuse prevention and treatment services provided by public and private agencies, and to parents and children or their representatives involved in legal proceedings resulting from suspected child abuse.

The committee should conduct periodic evaluations of the policies and practices, with respect to child abuse information collection, retention, security utilization, of *all* agencies involved in the local and state child abuse system, including the following areas of inquiry:

- The specific information that is being collected;
- The reliability of the information that is being collected; the means for determining reliability and evidence of their effectiveness;
- The purpose of collecting the information;
- Evidence of the extent to which the information collected is used for the purposes for which it is collected;
- The risk that the information may be misused or misinterpreted;
- The safeguards implemented to minimize such risks and evidence of their effectiveness;
- The extent to which the information or the means of collecting it may constitute an invasion of privacy;
- The ways in which the information collected is utilized for making specific decisions defined in the model child abuse intervention system.

The results of this evaluation should be made available to the agencies involved, to the legislative, executive and judicial branches of government, and to the general public.

(2) *General standards for the collection, retention and utilization of information.* An agency should only collect information pertaining to an identifiable child and a parent, guardian or caretaker if:

- Reasonable safeguards have been established to protect against the misuse, misinterpretation and improper dissemination of the information;

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*The standards and policies pertaining to the collection, retention and disclosure of information discussed in the following sections closely follows those developed by Professor Michael Altman in the draft of his volume, "Juvenile Records and Information Systems," prepared for the IJA/ABA sponsored Juvenile Justice Standards Project.

- The information is accurate, relevant and necessary;
- The information will be utilized within a reasonable period of time for specified purposes;
- The collection of the information does not involve an invasion of privacy; and
- A periodic evaluation by the Committee indicates that the policies and practices with respect to information collection, retention and utilization and the type of information collected and retained are reasonable and reliable.

(3) *Civil remedy for improper information handling.* The legislature of each state should promulgate a statute making it a tort to improperly collect, retain or disseminate information pertaining to children or their parents involved in services or legal proceedings connected with child abuse remedies. In cases of improper collection, retention or dissemination, where actual damages are incurred, a child should be entitled to monetary compensation; to an appropriate equitable remedy, if the improper act has not been corrected or there is a reasonable possibility that the improper act may be repeated; punitive damages if it is established that the improper act was willful; and to attorneys fees and costs if the child establishes that the collection, retention or dissemination of information was improper.

(4) *Correction of records.* Rules and regulations should be promulgated by each agency involved in child abuse-related activities which establish a procedure by which a child, his/her parent or guardian, or their representative, may challenge the correctness of a record and which further provide for proper notice to be given to each child and adult who is the subject of a record of the availability of such a procedure. The procedures established to provide an opportunity to challenge the correctness of a record should include the right to a hearing before an official of the agency who has the authority to make any corrections that may be necessary as a result of a challenge. Such rules and regulations should be reviewed and approved or disapproved by the Child Abuse Information and Records Committee.

(5) *Rights of Subjects.* Information collected in the Child Abuse Information File should not be retained without informing the parents and, if appropriate, the child or his/her representative, that:

General rights:

- The information has been retained;
- They have a right of access to the information;
- They have a right to challenge the accuracy of the information as well as the agency's right to retain the information; and
- They have a right to add their own comments or interpretations to any record that is retained in accordance with procedures established by the courts.

Access to records and information. A child, his/her parents and their attorneys should, upon request, be given access to all records and information collected or retained by any agency which pertain to them, except for the names of reporters and when the information is likely to cause severe psychological or physical harm to his/her parents. Each state should establish specific procedures to determine this condition which are reviewable by the committee.

Identifying records and information used for research purposes. Identifying information should not be collected for research purposes unless:

- The child and his parents have been informed of the purposes for which the information is to be collected; safeguards have been established to assure the security of the information and the right of the child or his/her parents to refuse their consent to the collection of such information for research purposes; and
- The written consent of the parent has been obtained and the child is over 14 years of age.

Third party access to records and information. Access or indirect access to a record or the disclosure of information pertaining to an identifiable child or adult should only be accorded to a third person under the following circumstances:

- The informed consent of the child, if over the age of 14, and his parents, is obtained;
- The person to whom access or indirect access is to be made executes a written non-disclosure agreement;
- The child, if over the age of 14, and his/her parents are informed of the specific information to be disclosed, the purposes of disclosure and the possible consequences of disclosure; and

- The agency that has possession of the information has re-evaluated the information within the past ninety days and has determined that, to the best of its knowledge, the information is accurate, or is otherwise prepared to attest to its accuracy.

Performance, utilization and release of medical, diagnostic and social studies. Before commencing a medical or a diagnostic study, as a result of a referral to a hospital by the ICEU or referral by a juvenile court, a professional person responsible for the examination or study should inform the parents and, if appropriate, the child of: 1) the purpose of the study; 2) the persons or agencies that will have access to the study; 3) the persons who will conduct the study; and 4) the rights of the parents with respect to consent to the study.

Before forwarding the findings, conclusions or results of a medical or diagnostic study to a county/city attorney or to a juvenile court, a person responsible for the examination or study should review and explain the contents of the report with the parents and, if appropriate, with the child. If the native language of the parents is not English, the report should be translated or it should be reviewed and explained to them in their native language. The parents should also be informed that they have the right to make additions or corrections to a diagnostic report, and, if they do so, those additions or corrections will either be incorporated into the diagnostic report or noted in an appendix to the report.

Before forwarding an examination or a diagnostic report to a county/city attorney or to a juvenile court, a professional person responsible for the report should determine that the information included therein is: 1) verified and accurate; 2) relevant to a matter for which the examination or study was undertaken; 3) needed for the purpose of making a lawful decision; 4) written in a form that is understandable to the recipient and that, to the extent possible, limits the risk of misinterpretation; and 5) includes notations as to the sources of all information included in the report.

A social or psychological history, or any portion thereof, should not be released to any person or agency, even if consent is obtained, unless:

- The agency or person that is to receive the history executes a written agreement not to release any portion of the history to third persons and promises to utilize the history solely for the purposes of treatment, further on or providing services, and
- The juvenile, if he/she is fourteen years of age or older, or otherwise his parent or guardian, has been fully informed of the purposes of disclosure, the general nature of the material to be disclosed and the agency or person to whom disclosure is proposed.

An agency that intends to utilize a social or psychological history for purposes of determining whether to remove a child from its home should provide copies of the history to the juvenile's attorney, to the juvenile, if he/she is older than fourteen years of age, or otherwise to his parent or guardian. If the native language of the juvenile, his parents or guardian is not English, the history should be appropriately translated. If the history contains professional jargon or other information that may not be understood by the juvenile and/or his parent or guardian, the history should be translated and explained to them by the appropriate professional or para-professional.

(6) *Feedback to reporters.* A consistent complaint of hospital administrators or physicians is that, once a case is reported, they receive no feedback on its disposition.(53) Without this feedback, they are unable to assess their disposition experience to aid them in handling future cases. Private physicians and schools also are unlikely to increase reports unless they have the right to receive, upon request, a summary of the actions taken on cases in response to their report. Thus, it is recommended that the person in charge of a hospital, a school or a physician making a report be authorized to make a written request to receive a confidential report, which may not be publicly disclosed, on the status of the case at the time of the request and, subsequently, the ultimate outcome of the case. At the same time, the family involved should be notified that the request for such information has been received and, unless the parent or a legal representative presents valid objections to a designated hearing officer within a specified number of days (e.g., 10 days), the request would be honored.

(7) *Removal of records from the child abuse information file.* In cases involving a child abuse complaint or petition, all identifying records per-

taining to the matter should be destroyed when: the application for the complaint or petition is denied; the complaint, petition or criminal charge is dismissed; or the case is adjudicated not child abuse or the defendent is found not guilty.

In cases of adjudicated child abuse, all identifying records pertaining to the matter should be removed from the Child Abuse Information File when the case has been discharged from the supervision of the court and two years have elapsed from the date of such discharge in the case of a criminal proceeding against the parent, or one year has elapsed from the date of discharge in the instance of a civil proceeding; and when no subsequent court proceeding is pending as a result of the filing of another child abuse petition or charge.

An agency that has a social or psychological history or a court that has received a copy of such a history should destroy that history and all references to it when the juvenile becomes eighteen years of age or, in the case of a juvenile who is subject to the custody of an agency beyond he age of eighteen, the history and all references to it should be destroyed when the juvenile becomes twenty-one years of age. If the agency has "closed" the case of a juvenile who is the subject of a history, it may destroy that history and all references to it prior to the juvenile's eighteenth birthday. Upon destruction of a history, the agency shall notify all other agencies to which it has sent copies of the history who should immediately destroy all notations or references in its files pertaining to that history.

(8) *Use of computers for the child abuse information file.* The decision to use a computerized system to store information and records pertaining to identifiable children and parents involved in child abuse interventions should be subject to evaluation, review and approval by the Child Abuse Information and Records Committee. The basis for evaluation should include a detailed description of the system to be utilized, the data to be stored in the system, the purposes of the system, the quality controls to be provided, access and dissemination provisions, methods for protecting privacy and assuring system and personnel security, and provision for a periodic independent audit by the Committee or its designee. The data included in such a computerized system should be only minimal, objective, and factual, and should not include data of a subjective, evaluative or diagnostic nature. The persons whose records are to be computerized should be identified by an arbitrary nonduplicating number instead of by name.

The information system should not be linked to a centralized computer system or share information with other computer systems or centralized information systems of any type. Before approving the proposed system, the Child Abuse Information and Records Committee should publicize the fact that a plan for computerization of the Child Abuse Information File has been filed, make the plan available to interested citizens, groups and agencies and hold a public hearing to receive comments and evidence with respect to the plan. Upon approving a proposed computerized system, the Committee should issue written findings and those findings should be made available to the public.

3. *Minimizing child removal.* The criteria currently applied and the procedures followed for emergency, temporary, and permanent removal of children from their homes are ill-defined.(54) Removal processes center around decisions made by physicians (in the case of emergency removal), police (again, emergency removal), and protective service workers (emergency, temporary, and permanent removal). Applications of removal criteria by physicians in hospitals appear to center on observable physical conditions of the child, with some input from the social service staff.(55) Protective service workers may initiate action for removal of children at any stage of their involvement with a family.(56) They may use as the basis for such decisions information gathered in their capacity as "helping" agents with the parents, and are less scrupulous about informing parents of the possibility of such legal action than are, for example, police schooled in the application of Miranda and other warnings, or physicians who are quite sensitive to the issues of potential lawsuits and the limits of their authority.(57)

Ordinarily, as soon as possible after the local child welfare agency receives a report of child abuse (or neglect) from any source, a caseworker is sent to the home to evaluate the home situation. If the child has not already been removed, and the caseworker feels this is necessary to protect the child, the caseworker will request a court order for this purpose.(58) In many states a custody hearing must be set within a stated time (48 or 72 hours) after the child is removed. At the custody hearing, the parents may be advised of their rights and a determination of probable cause made. The court's decision often is based heavily on the protective caseworker's report. Counsel may be appointed for the child and parent or a guardian ad litem may be appointed by the court to represent the child.(59) If the matter is not contested, the hearing could move into the adjudication and disposition hearing at this time. If the matter is contested, either a pre-trial conference or an adjudication hearing is set.

In a dependency and neglect proceeding, there is little in the way of standards that can guide judicial decisions where there is not a preponderance of evidence that physical injury has been inflicted on a child.(60) The primary decision of the court has to do with removal of the child, temporarily to foster care, or termination of parental rights preparatory of adoption. The judge's decision at best can be guided by the standard of "least detrimental available alternative" which "minimizes disruptions of continuing relationships between a psychological parent and the child."(61)

One of the major factors which influence a court's decision to remove children is the "cooperation" of the family with "treatment personnel," i.e., the protective service worker.(62) Clear and specific written criteria for the decision to remove a child from the home were not found in protective service agencies in the communities visited; the decision is often admittedly a subjective one based on the response of a parent to an individual worker. The protective service worker's perception of parental stability, receptivity to services, and "treatability"—that is, willingness to change, are important factors.(63) Paradoxically, a parent who acknowledges abusive behavior is considered "treatable" and thus less liable to removal of the child than a parent who insists that no abuse has occurred ("denial" in case-worker parlance).(64) Parents who are more articulate and thus more skilled in "therapeutic" role-playing may well fare better in a caseworker-parent relationship than a less articulate parent, regardless of other elements of the situation.

There is no specified set of actions or services which must be provided before removal is considered the appropriate action. The frequent reliance of protective service departments on removal (and, more frequently, the threat of removal) is the more disturbing because of evidence that, once a child is removed, the family may never be reconstituted: "temporary" removal of a child in a large percentage of cases becomes a permanent loss of the child to the family.(65) Further, the trauma to the child of removal, and the response of the family to "close in" and exclude the removed child, are seldom even recognized by protective service workers.(66) The emotional costs to the child and family of removal often tend not to be included in the decision-making process that results in child removal. It is approached as either "protecting" the child from harm, or not "protecting" it, by taking it out of the natural family setting.(67) Harmful consequences of state intervention, such as placement in jail-like institutional settings and exposure to strange and unsympathetic people and experiences, were rarely acknowledged (with notable exceptions) by protective service workers interviewed in community visits. It is as though some ideal imaginary environment is posited as the alternative to allowing the child to remain in the home.(68) Actual monetary costs of placement of children outside the home also may not be weighed against the cost of services which might permit the family to remain as an intact functioning unit — assuming they are available, which generally is not the case.(69) These services include day care, homemaker services, emergency budgets, and other supportive services. Too often the rescue fantasies of young and inexperienced workers, coupled with the non-existence of services which might allow the family to continue functioning, result in costly, punitive, and potentially destructive separation of the nuclear family.(70)

Site visit discussions revealed that, on a daily operational basis, there usually is no agency monitoring the protective services agency and no forum of appeal for families affected except the same courts which most often rely on the judgments of protective services workers in formulating their decisions. In several of the communities visited where excessive child removal or criminal actions were being restrained, it is interesting to note that it was the outcome of influence and decisions of an individual judge, district attorney or hearing officer.

In most states, law enforcement officers are authorized to place children in protective custody, based on their general law enforcement powers or through child protective legislation. The right of physicians or a hospital to retain custody of a child, without the consent of the parents or guardians and without a court order, is a trend gaining acceptance. Under present practices, protective service workers make the initial decisions about handling maltreatment cases and the advisability of court action. Under the proposed model, protective service workers would not have the prime initial decision-making responsibility in most abuse cases. Consequently, we do not recommend granting them custody powers. In urgent situations where child removal under protective custody is necessary, the child welfare worker should call a law enforcement officer. The model system's strategy for drastically reducing inappropriate child removal in the handling of suspected abuse cases is comprised of the following elements:

- Protective custody powers under the proposed model system would be used only in situations where there is reasonable cause to believe that the child's life or health is in sufficiently imminent danger that immediate medical treatment and a hospital examination is necessary, and/or there is no time to apply for a court order, and the parents or guardians are unwilling to consent to the need to remove the child from the home.
- When the safety or well-being of a child suspected of being abused appears to be endangered, a law enforcement or child protective agency investigation would *not* be initiated; rather the child would immediately or as quickly as possible be examined by a special unit of medically trained persons for injuries to determine the existence, nature, and severity of the injuries. If the injuries did not warrant hospital examination, or hospital examination indicated that the injuries did not warrant legal action, the parent or other person responsible for the child's welfare would be informed of the availability of voluntary emergency services. Refusal of such services would not be the basis for a court order or other legal authority to protect the child (unless there was a CAIF record of previous legal action against the parents or guardians for child abuse).
- In instances where law enforcement officers on ICEU staff take a child into protective custody for placement in an appropriate medical facility, they should promptly initiate proceedings in court and, where the parent or guardian is not present at the time of custody, immediately notify the parent or guardian of the action taken (orally and/or in written form). On the assumption that the injured child is taken only and directly to an appropriate medical facility, the court would expect to receive from the hospital, within 48 hours after hospital admission, a request for a temporary restraining order for an additional 48 hours, or the child would be released to its parents. If the child is not released by the hospital within 48 hours, and the hospital, for any reason, does not request an extension of temporary custody, the court would commence a shelter care hearing to determine whether continued custody is necessary.
- Whether a child is brought to a hospital by a law enforcement officer or an ICEU worker, or is admitted for outpatient or inpatient services, protective custody by hospitals, without parent/guardian consent and without a court order, only extends for 48 hours. In the instance of children with suspicious injuries admitted for outpatient or inpatient services, without law enforcement or protective custody, only the person in charge of the hospital should be permitted to place a child in protective custody without a court order, for 48 hours and only while the child is undergoing treatment for *and* examination of suspicious injuries. If the head of a hospital has reasonable cause to believe that the child's home environment is dangerous, or any other reason to be concerned about the safety of the child, and the child is *not* undergoing treatment for and examination of suspicious injuries, we would recommend authorizing only a twenty-four hour hold, except on weekends when the child can be held only until Monday morning (and not the next weekday session of the Juvenile Court).
- In the instance of protective custody of suspected abuse cases by law enforcement officers, the only place to which a child should be taken directly is a Child Injury Medical Center licensed by the state to perform the necessary medical examination of suspicious injuries or, if one does not yet exist, to an appropriate medical facility. This means that a child in protective custody in connection with suspected abuse, by the definition of abuse used in this proposed model, initially would not be

taken to a foster home, group home, shelter, or other non-medical facility, and, under no circumstances, would be placed in detention facilities or jail.

- Parents and child in custody hearings would have the right to counsel and, if they are indigent, the right to appointed counsel, with right to notice and hearing; the right to a bifurcated (adjudication and disposition) hearing on abuse; and the right to a separate dispositional hearing on the issue of termination of parental rights.
- Permanent removal should be restricted to cases where it is necessary because it is the *only* feasible way to protect the physical well-being of the child, i.e., less drastic alternatives are not available.

4. *Legal representation of parents and child.* Under present laws, there is a wide variety of provisions governing legal representation of parties in civil child abuse proceedings. Such provisions range from no mention at all concerning a right to counsel, through specification of a right to counsel, and a right to appointed counsel for all parties (i.e., parent and child) and include all conceivable variations in between.(71) In some jurisdictions there is provision for a guardian ad litem.(72)

The strategy of the proposed model system involves a diagnostic screening process which may ultimately lead either to civil court processing or non-intervention in terms of legal process, in the family unit, possibly combined with noncoercive and voluntary provision of emergency services.

Under the model system, protective services and all other agencies or persons may refer cases to a CIMC for examination which only then are determined to qualify for referral to the county/city attorney for a petition. The county/city attorney may conclude that there is insufficient evidence or that, for other reasons, the child's interests indicate that court action is an inappropriate intervention. In other words, the decision to file a petition becomes a legal decision by the locality's civil law officer. Specific harm to the child, and not parental/caretaker fault concepts, would determine the need for court intervention.

The petitioner in all civil cases in the proposed system should be the locality's civil law officer (e.g., the county attorney or city corporation counsel) and not, as is often the case, the local child protective service agency, which often has post-dispositional service, treatment and/or case management responsibility. This proposal in the model system attempts to solve two problems: the conflicting dual role of protective services as "petitioner" and "helper"; and the increasing legal demands on protective services, which go along with increasing (and under the model system required) defense counsel participation for pre-trial investigation, case preparation, petition drafting, courtroom presentation, legal argument, etc.

In weighing the advantages and disadvantages of reliance on civil court process as the final arbiter of child abuse, we are persuaded of its potential value for minimizing discriminatory, discretionary and quasi-legal decision-making on less than serious child abuse cases outside of the legal system. Thus, the proposed model system of handling child abuse is designed to screen out those cases which should not be subjected to legal, or quasi-legal, or coercive intervention of any kind and to legally process the remainder, under a limited definition of child abuse, through judicial determinations consonant with high standards of modern family law.

In implementing such a strategy, adherance to strict due process standards is essential if fundamental fairness is to be insured. Recognizing that access to legal representation is the key to the protection of due process rights, the model system proposes such legal representation for all parties.

Any child who is alleged to be abused and any parent or other person responsible for that child should have independent legal representation in a civil proceeding and court-appointed counsel at public expense where they are unable to afford such representation.(73) The child's attorney should not also serve as his/her guardian ad litem in civil proceedings. A guardian ad litem should be appointed who need not be a lawyer but should be familiar with the law and legal procedures in child abuse cases.(74) This guardian ad litem should not be the local child protective service attorney since the interests of that agency may conflict with those of the child, just as the interests of the parents and child may conflict.

a. *Legal representation for the child and guardian ad litem.* In a civil child abuse proceeding, the parties are state or local agency, on the one hand, and the parents or custodian of the child on the other. The primary focus of the dispute is the custody of the child with the representative of the state or locality arguing that custody should be removed from the parents and the parents presumably arguing, with or without assistance of counsel, that their custody of the child should continue. Without the child, there would be no dispute. Yet often, with the child thus caught in the middle, there is no one specifically designated to represent the child's viewpoint in the dispute. The attorney for the state or local agency ostensibly represents the "best interests of the child." In practice, such interests are represented, if at all, not independent from the position of the other party, but rather from the perspective of the attorney's client, i.e., the public agency.(75)

As noted above, a number of jurisdictions provide for either independent counsel or a guardian ad litem—who may or may not be an attorney—for the child. There are pros and cons to both approaches, and controversy over the question of whether a guardian ad litem needs to be an attorney. Where a guardian ad litem is not an attorney, it is argued that the child's legal rights will be fully or adequately protected. On the other hand, in several of our site visits staff observed a tendency for the child's counsel to side with the position of the attorney for the petitioning agency. According to both counsel for the child and counsel for parents that we interviewed, the position adopted by counsel for the child is most often essentially identical with the position of the state (city, county, or welfare department) attorney at the adjudication stage.(76)

The model system proposes that the child's right to independent counsel be recognized and that such counsel be appointed at court expense or provided through an arrangement with a legal aid society, legal services program, or the like, when the child (not the parents) is unable to afford private counsel. This right to counsel should attach at the earliest point in the proceedings.

In addition, under the model system, a separate guardian ad litem should be appointed in those cases where the child is not of sufficient age and mental capacity to comprehend the proceedings and participate in the representation of his interests. This proposal is made with full recognition of the fact that there is not now, nor will there be in the near future, adequate resources for implementation.

Persons of sufficient age and mental capacity are able to participate in the representation of their interests by confering with their attorney, participating in strategy decisions, expressing their desires and directing that these be recognized in the legal posture adopted by the attorney on the client's behalf. Obviously, this is not the case with small children. Where an attorney or guardian ad litem alone is assigned to represent the "best interests" of the child, this duty may conflict with what the interest or desires of a child would be if the child were capable of expressing them. Such conflicts have arisen in the representation of older children capable of expressing their opinion.(77) The presence of both an attorney and guardian ad litem for the child would permit a separation of roles in determining the "best interests" of the child.

The role of the attorney would be to insure that the legalities of the proceedings are correct, that the child's rights are being protected and that the child's interests are being adequately presented and considered. The role of the guardian ad litem would be to determine, on behalf of the child, what posture to adopt in the proceedings. The guardian ad litem would consider the child's separate interests as well as the child's interests as a member of a family unit. The guardian ad litem would perform a social investigation from the child's perspective and, on behalf of the child, explore dispositional alternatives that would strike a proper balance between protection of the child and the continued presence of the child in the family unit. Furthermore, the guardian ad litem would insure that the child's interests are protected in the post-dispositional phase so that (s)he is ultimately placed in a stable environment which promotes the establishment or re-establishment of a "psychological parent-child relationship" in accordance with the "child's sense of time."(78) For this reason, legal procedures (and laws) aimed at protecting children should reflect developmental differences, including the sense of time, among children at different ages.

It is not presupposed that a single representative of the child (who should be an attorney) cannot adequately perform both roles. However, in representing a young child incapable of providing assistance in the legal process, under such an arrangement an individual is called upon to do both the thinking and the acting of two persons, i.e., the attorney and the client.

b. *Necessity of representation for parents.* We have observed that, in addition to all involved professionals (physicians, protective service workers, hospital personnel, probation workers, and public counsel) who profess to operate "in the best interests of the child," there are numerous organizations who volunteer or receive public funding to provide specific legal representation to children in neglect and dependency proceedings. Examples include publicly funded guardians ad litem, who may be permanent employees of the court, and such organizations as the Juvenile Justice Clinic of Georgetown Law School,* where students provide legal representation and social service investigation for children in neglect hearings in return for academic credit. These legal resources for children, albeit limited, still are in stark contrast with the situation of parents involved in neglect proceedings, who very often are provided no legal representation whatsoever. In jurisdictions observed during site visits, parents may be represented by counsel in civil actions if they insist upon representation; they may be represented only if they personally can afford to retain counsel (a clear minority of cases); or they may be provided with more or less perfunctory representation by counsel who are not compensated by the state, but rather required to accept neglect cases as a condition of receiving delinquency case appointments paid for by the court.(79)

As previously noted, counsel for the child and counsel for the state agency often adopt identifical positions, particularly at adjudication. Thus, there may be two relatively well-funded attorneys, possibly with investigative and social service staff resources representing the position that given parents are abusers, while the parents may be poorly represented, if at all. Under the model system, the parents right to counsel would be recognized as well as their right to appointed counsel at public expense where they cannot afford private counsel. Any waiver of counsel should not be accepted except on the record in open court and only after the parent has consulted with an attorney designated by the court. Notice of the right to counsel should be provided at the earliest point that abuse is suspected and no further questioning should occur until the opportunity to obtain counsel has been granted and counsel has either been retained, appointed or properly waived.

Appointed counsel for parents should be provided either through arrangement with a legal aid society or legal services program different from the source of counsel for children, or from a public defender program or a panel of private attorneys appointed from a list which is maintained by the court and who are reimbursed out of court funds or other public funds.

The emphasis here, then, is upon a most critical need: assuring minimal adequate representation of parents in civil proceedings funded publicly in the event parents cannot afford to retain legal counsel themselves. It also should include investigative and social service personnel to the extent necessary to establish the parents' legal position and to devise adequate dispositional alternatives.

c. *Standards for counsel.* The participation of counsel on behalf of all parties subject to civil child abuse proceedings is essential to the strategy of the model system. In addition to the participation of counsel, certain standards should be met both with respect to the provision of counsel and the performance of counsel.(80)

- To insure competent and adequate representation, adequate provision for supporting services must be made available. Such supporting services should include investigatory, expert (medical, psychiatric, psychological) and other non-legal services. These should be available to counsel and client at all stages of the proceedings.
- Any plan for providing counsel to private parties should be designed to guarantee the professional independence of counsel and the integrity of the lawyer-client relationship.
- Counsel should be provided in a systematic manner and under a coordinated plan which assures independent sources of counsel for parents and children.
- Appointments through defender systems or legal aid/ legal services systems should be made in a manner that takes into account the caseload and experience of the staff, and the complexity of pending and foreseeable litigation.
- Appointments of counsel from a panel of private attorneys should take into account the same caseload, experience, and complexity of litigation factors above. In addition, such appointments should be made in a rational, systematic sequence. An adequate plan for compensation and reimbursement of counsel for necessary legal and supportive services should be developed and implemented. Neither the appointment nor the compensation of counsel should be or appear to be contingent upon counsel's relationship with the court.
- Counsel involved in child abuse proceedings, as all members of the bar, is bound

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*See Appendix III (III-11)

to know and is subject to standards of professional conduct set forth in statutes, rules, decisions of courts, and codes, canons or other standards of professional conduct.

- A lawyer engaged in child abuse proceedings typically deals with social work and protective services agency personnel and should cooperate with their avenues and instruct the client to do so unless such cooperation will jeopardize the client's interests or rights.
- Lawyers involved in representing parties in child abuse proceedings should qualify themselves for participation in such proceedings through formal education, association with counsel experienced in such proceedings, or by other means.
- Where counsel is appointed for the child and the child is capable of considered judgment on his own behalf, determination of the client's interest should ultimately remain the client's responsibility after full consultation with counsel.
- Where a child is incapable of considered judgment on his own behalf and a guardian ad litem has been appointed, primary responsibility for determination of the posture of the case rests with the guardian and the child.
- Where a guardian ad litem is not appointed, the attorney should ask that one, other than himself, be appointed. Where a guardian is not appointed, counsel should inquire thoroughly into the child's desires, his needs, the community facilities available, and all other circumstances that a careful and competent person in the child's position should consider.

NOTES

(1)Kempe *et al.*, see Section I.A. n. 5 *supra*.

"A major diagnostic feature of the syndrome is a marked discrepancy between clinical findings and the historical data supplied by the parents; and the syndrome should be considered in any child exhibiting evidence of fracture to any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma. . ."

(2)DeFrancis and Lucht, see Section I.A. n. 13 *supra*.

(3)*Ibid.*

(4)Fontana, see Section I.A. n. 37 *supra*.

This book provides a survey of the problem of "Maltreatment" in the U.S. and especially in New York City, and an impassioned plea for more public and private efforts at prevention and treatment.

(5)Fraser, see Section I.A. n. 15 *supra*.

Legislative approaches to the problem of child abuse include mandatory reporting statutes which now exist in all 50 states. This article explores the characteristics of the reporting laws, including the definitional aspect. "Usually this includes any non-accidental or serious physical injury, but it is often broadened to include neglect, sexual abuse, and in a few states emotional abuse."

Cohen and Sussman, *Model Child Abuse Law*, see Section I.A. n. 17 *supra*.

The model law drafted by Sussman and Cohen defines abuse as: "An abused child is a person under 18 years of age who is suffering serious harm or sexual molestation caused by those responsible for his care or with temporary or permenant control." Suggested alternative definitions might include: "(1) Harm suffered need not be 'serious' enough to constitute abuse or neglect; (2) a child shall be considered abused or neglected if seriously 'threatened' with harm; (3) abuse shall include serious 'mental' as well as physical harm.

(6)DeFrancis and Lucht, n. 2 *supra*.

The preface of this volume notes that the nature of the statutes may be punitive or curative, i.e. identifying abused children for purposes of social planning to prevent further abuse and for meeting the needs of the family, as opposed to identifying the perpertrator solely for the purpose of punishment.

(7)Gil, see Section I.A. n. 56 *supra*.

Based upon national surveys conducted in 1967 and 1968, it appears that while physical abuse of children occurs in each strata of society, the incidence rate is significantly higher among economicallly deprived segments of the population.

Light, see Section I.A. n. 14 *supra*.

(8)Katz, see Section I.A. n. 64 *supra*.

(9)Gil, n. 7 *supra*.

Gil speculates that the living conditions of low-income and minority groups involve comparatively more daily stress and frustration, which are reflected in lower levels of self-control and in a greater propensity to discharge angry and hostile feelings towards children. He noted further that economically deprived families tend to live under more crowded conditions; the rate of one-parent families is higher; parents have fewer opportunities to arrange substitute care for their children; and having fewer educational opportunities, parents' child rearing methods are more traditional with more reliance on physical discipline.

(10)Michael Wald, "State Intervention on Behalf of Neglected Children: A Search for Realistic Standards," *Stanford Law Review*, April 1975.

(11)Fontana, n. 4 *supra*.

". . .it [isn't] always the physically injured child who sinks most deeply into himself. Sometimes the child with burns and fractures responds more readily to treatment and friendly overtures than the child who shows no evidence of inflicted injury. . .There must be something more to child abuse than just the battered child syndrome."

E. Maginnis, E. Pivchik and N. Smith, "A Social Worker Looks at Failure to Thrive," *Child Welfare* 46:335-38 (1967). [AB#35]

Failure to thrive is a syndrome of infancy and early childhood characterized by growth failure, malnutrition, and retardation of motor and social development. A 1964 study of 151 children admitted to Boston's Children's Hospital Medical Center with a diagnosis of failure to thrive showed that 42 of the 50 children with no primary organic illness were under the age of 2, the average being 12.5 months.

B.S. Koel, "Failure to Thrive and Fatal Injury as a Continuum," *American Journal of the Disadvantaged Child* 118:565-568 (1969). [AB#33]

This article, summarizing theories of causation of failure to thrive, offers three case histories illustrating that failure-to-thrive infants may be at risk of serious injury or violent death in the ensuing months. Koel sees failure to thrive on a continuum with abuse and fatal injury.

(12)Cohen, *Child Abuse Reportial Practices and Services*, see Section I.A. n. 54 *supra*.

(13)Vincent DeFrancis, "Protecting the Child Victim of Sex Crimes Committed by Adults," *Federal Probation* (American Humane Association, Children's Division, 1971).

(14)Wald, no. 10 *supra*.

(15)*Ibid.*

(16)Suzanne Sgroi, "Sexual Molestation of Children," *Children Today*, May-June, 1975.

(17)*Ibid.*

(18)Shirley Camper Soman, *Let's Stop Destroying Our Children: Society's Most Pressing Problems* (New York: Hawthorne Books, 1974).

"[The sexual offender] was reported to be a fine, normal young man by fellow teachers. His picture appeared in the newspaper. He looked strange – staring, wild-looking – strange enough to satisfy anyone's feelings. . .that he really is very different from the rest of us."

(19)"Interviewing the Child Sex Victim," *Training Key #224* (International Association of Chiefs of Police, Professional Standards Division, 1975).

"Younger children may be genuinely confused about the attack. The victim may know that something unusual occurred, but not that something 'bad' or significant took place. . .The concept of 'protection through innocence' should be recognized by police officers. The premise of the concept is that the young child, because of her lack of awareness of social taboos violated, will not suffer a long-lasting emotional disturbance from a sexual assault."

(20)DeFrancis, n. 13 *supra*.

(21)*Ibid.*

(22)*Ibid.*

(23)*Ibid.*

(24)Wald, n. 14 *supra*.

(25)DeFrancis, n. 13 *supra*.

(26)Training Key #224, no. 19 *supra*.

(27)Wald, n. 14 *supra*.

(28)*Ibid.*

(29)*Ibid.*

(30)E.H. Bennie and A.B. Sclare, "The Battered Child Syndrome," *American Journal of Psychiatry* 125(7):975-979 (1969). [AB#6]

"Lack of knowledge of the developmental skills of children results in excessive behavior demands."

Steele and Pollock, see Section I.A. n. 7 *supra*.

E. Pavenstedt, "The Meaning of Motherhood in a Deprived Environment," *Crisis of Family Disorganization: Programs to Soften Their Impact on Children*, E. Pavenstedt and V. Bernard, eds. (New York: Behavioral Publications, 1971), pp. 59-74. [AB#18]

"Another recurrent event is the history of orphanage or foster home placement of the mother early in life. It is precisely this finding that has led one to question reliance on placement away from home as a treatment measure. Most of the mothers who were placed during their childhood are extremely fragile; they have little energy to cope with their family or are chronically depressed or both".

N.A. Polansky, D. DeSaix, and S.A. Sharlin, *Child Neglect: Understanding and Reaching the Parent* (New York: Child Welfare League of America, 1972). [AB#19]

The author's study of neglecting parents concludes that the "apathy-futility syndrome" reflects a pervasive, deep-seated, and early damage in the maternal personality which is very difficult to reverse in adult life.

N.A. Polansky and N.F. Polansky, "The Current Status of Child Abuse and Child Neglect in this Country – 1968," Report to the Joint Commission on the Mental Health of Children, Washington, D.C. (University of Georgia). [AB#20]

The abusive parent is generally described as one who has a drive to destroy his child and shows the following characteristics: immature personality; no remorse at his behavior; refusal to seek or allow outside help; repetitiveness in his abuse; and neglect or abuse in his own childhood.

James D. Delsordo, "Protective Casework for Abused Children," *Children* 10(6):213-218 (November-December, 1963). [AB#12]

Parents exhibiting overflow abuse are unable to cope with ". . .their own frustrations, irresponsibility, and lack of belief in themselves and anything else." They compensate by abusing anyone or anything, especially a child who becomes a burden for them. They lack the mental and physical energy necessary to establish a healthy family environment.

(31)Kempe and Helfer, eds., *Helping the Battered Child*, "Status of Child Protective Services," see Section I.A. n. 31 *supra*.

Child Abuse can be seen either as a social problem or a criminal offense. Therefore, it must be decided whether the goal of child abuse reporting is to prevent further abuse, safeguard and enhance the welfare of such children, and, when possible, preserve the family unit, or the goal is the prosecution of a criminal act.

(32)Cohen, Child Abuse Reporting Practices and Services, n. 12 *supra*.

This study finds that the major reason for underreporting, especially by private physicians, is due to unfamiliarity with the law, fear of involvement in lengthy legal processes, effects on doctor-patient relationship, and fear that reporting would not be constructive because of the lack of available treatment services.

(33)Levine, see Section I.A. n. 55 *supra*.

"Requests for investigations and the implementation of services rarely eminate from the parents, instead, they arise from complaints by different segments of the community, most often from relatives, neighbors, clergy, police, and other social agencies with whom the parent has had contact."

Yvonne M. Tormes, "Child Victims of Incest – A Substudy Based on Data Produced in Research 'Protecting Child Victims of Sex Crimes Committed by Adults" (The American Humane Association, Children's Division).

The following statement, although made explicitly concerning father-daughter incest, is not limited to this category of abuse: "It appears, from the material presented thus far, that family attempts to arrest the offenders behavior through public interference, seem to occur most frequently when the family's solidarity is broken by antagonisms within the family (pregnancy or family quarrels). This family's solidarity against outside interference is further corroborated by the fact that after the initial complaint was filed, four families moved, or changed the testimony, and the offender could not be convicted.

(34)Cohen, Stephen J., "A National Survey of Attitudes of Selected Professionals Involved in the Reporting of Child Abuse and Neglect" (New York: Institute of Judicial Administration, Inc., American Bar Association, Juvenile Justice Standards Project) (Unpublished Manuscript) [AB#48]

One finding of the study was that most respondents to the survey viewed existing reporting laws as satisfactory. The main systemic defect – underreporting – seemed closely related to the respondents' dissatisfaction with the implementation of those laws and the provision of services.

(35)Fraser, see Section I.A. n. 15 *supra*.

(36)Sanford N. Katz, Melba McGrath and Ruth-Arlene W. Howe, "Child Neglect Laws in America," *Family Law Quarterly* 9, no. 1 (Spring, 1975).

(37)*Ibid.*

"Neglect is an uncertain concept both legally and in social application. Its most obvious definition is a chronic failure by adults to protect children from obvious physical danger. . .But the concept of neglect can also include the failure to ensure the positive social and psychological development of the child under this definition."

Fontana, n. 4 *supra*.

A. Kadushin, *Child Welfare Services* (New York: Macmillan, 1974). [AB#15]

"Neglect appears to be a response to social stress. More often than not, the neglectful mother has no husband, is living on a marginal income and in substandard housing, and is responsible for the care of a typically large family of children."

"Abuse appears to be a response to psychological stress. The parent is reacting to internal conflicts, selects one child in the family as a victim and responds to his misbehavior in a disproportionate manner. Families referred for protective services are generally socially isolated families."

(38)Light, see Section I.A. n. 14 *supra*.

(39)Monrad G. Paulsen, "Child Abuse Reporting Laws: The Shape of the Legislation," *Columbia Law Review* 67, no. 1 (January, 1967). [AB#108]

"Without adequate resources to back up a reporting plan the entire effort is an exercise in futility. . .No law can be better than its implementation, and its implementation can be no better than the resources permit."

(40) James W. Carpenter, "The Parent-Child Dilemma in the Courts," *Ohio State Law Journal* 30 (Spring, 1966), pp. 202-309. [AB#89]

A good statement of the conflict around abrogation of privileged communications can be found in the following: "Although at common law there was no privilege for disclosures made by a patient to his physician in the course of treatment, a privilege was created by statutes in the various states of the United States. Ohio followed other states which had established the statutory privilege. The Ohio statute prohibits a physician from testifying to a communication made to him by a *patient in that relation*. The purpose of the rule is to encourage disclosure by the patient so as to aid the physician in the effective treatment of disease and injury. This rationalization has been criticized as not being the real basis for the rule since patients rarely have in mind later litigation when they consult with their physician. However, this might well be the policy in a child neglect case where the parent would otherwise be discouraged from seeking treatment for a child in need of it if the parent suspects that he might subsequently be prosecuted for his conduct. Even so, it would seem that the parent is not the proper party to assert the privilege on behalf of the child, since the parent is not the patient, properly speaking, in such a case, but merely the person making the contract. . ."

(41) Brian G. Fraser, *Child Abuse and the Central Registry* (Denver, Colorado: The National Center for Prevention and Treatment of Child Abuse and Neglect) (Unpublished Manuscript). [AB#96]

Fraser cites a need for some leverage to force professionals to report suspected child abuse, and also for a "physical plant in which reports of child abuse are recorded and appropriately cross-indexed." There are three major goals of the registry:(1) to generate statistics on abuse; (2) to aid physicians and/or courts in the determination of abuse; (3) to track hospital and doctor shoppers.

Ibid.

Mr. Fraser feels that the transient nature of modern society precipitates a tracking problem (for abusing parents). The solution presented is a Federal Central Registry or, alternatively, the development of a central registry by each state with reciprocity agreements for the exchange of information. Fraser advocates the second alternative as being more acceptable to most people, and probably more feasible.

Newberger and Hyde, see Section I.A. n. 51 *supra*.

Statutes which provide for central registries do not always have expungement and limited access provisions, and it is well to remember that information submitted to such a registry may be used at a later date to raise the issue of the family's competance or risk to the child.

(42) Model Child Protective Service Act, see Section I.A. n. 23 *supra*.

(43) *Ibid.*

"All the information contained on the following initial, preliminary, progress, and final reports shall be entered in the central register . . .including an evaluation of the unmet needs of the child or family, and the causes thereof, including the unavailability or unsuitability of existing services, and the need for additional services, provided, however, that although a final report based upon a determination that the case is unfounded has been filed for the purpose of removing the case from the central register, the child protective service need not close a case even if the child or family is otherwise in need of services and voluntarily accepts such services."

(44) *Ibid.*

(45) *Ibid.*

"There shall be a central register of child protection cases maintained. . .shall be used to immediately identify and locate prior reports or cases of known or suspected child abuse or maltreatment in order to assist the diagnosis of suspicious circumstances and the evaluation of needs of the child and his family. . .including, but not limited to, the nature of cases reported and the provision of services, in order to measure the effectiveness of existing laws and child protection programs and the need for additional programs and to facilitate research, planning, and program development."

(46) *Ibid.*

(47) *Ibid.*

"Twenty-three states specify that reports are to be made to a single receiving agency. In 17 of these states the designated agency is a county or state department of welfare; five have designated a law enforcement agency to receive reports; and in one state all reports are made to the juvenile court. Of the jurisdictions not following the above pattern, twenty-one permit the person reporting to notify one of two or more specified agencies, with the remaining states requiring reports to two or more specified agencies."

(48) De Francis and Lucht, n. 2 *supra*.

"In 1970, only 19 states maintained central registries under legislative mandate with 26 others keeping centralized records as a matter of administrative policy. In the intervening 3 years, 14 states have been added to the list of those in which a central registry is required by law. Thus, in 33 states central registries are now mandated by law. Registries are maintained in 13 additional states and the District of Columbia by administrative policy.

(49) Paulsen, n. 39 *supra*.

"The existence of a central registry used for anything but statistical purposes raises sensitive issues of privacy. . .An entry in the registry can bring unjustified loss of reputation. Authorized persons are, after all, human beings who may react adversely to parents listed in the registry; further, no firm assurances can be given that the registry will only be available to authorized persons."

De Francis and Lucht, n. 2 *supra*.

(50) Light, n. 7 *supra*.

(51) Besharov, see Section I.A. n. 29 *supra*.

"Even before the passage of the Federal Child Abuse Prevention and Treatment Act of 1973, which requires reporting of child neglect as well as abuse, the states were broadening the circumstances requiring a report. More than three fourths of the states now include child neglect in their reporting laws, and a handful specifically mention sexual abuse and emotional abuse or neglect."

(52) Cohen and Sussman, "Incidence," see Section I.A. n. 12 *supra*.

"The only conclusion which can be made fairly is that information indicating the incidence of child abuse in the United States simply does not exist. This conclusion should not be interpreted as a plea for the more efficient collection of data, nor as an argument against the necessity for services. . .What will hopefully be gained from a reading of this brief paper, however, is that estimated rates of incidence, which often serve as 'evidence' demonstrating the need for legal or social programs, should be received with a degree of caution."

(53) Cohen, *Study of Child Reporting Practices and Services*, see Section I.A. n. 16 *supra*.

Reporters rarely receive feedback from the agencies to which they reported. This has a negative impact on reporting frequencies, especially for hospitals.

(54)Observations during site visits indicated that agencies performing emergency removal, or petitioning or making recommendations for removal of custody, seldom had written guidelines for making these decisions.

(56)*Child Welfare League of American Standards for Child Protective Service* (New York: Child Welfare League of America, Revised Edition, first printing: 1973).

"Placement of a child. . .should be carried out only when parents are unable to care for the child, when relatives or other persons close to the child cannot provide care for a temporary period, and when homemaker service or emergency service. . .is unavailable or inappropriate."

(57)V.B. Wylegala, "Court Procedures in Neglect: Caseworker and Judge in Neglect Case" (New York: Child Welfare League of America, 1956), pp. 9-16. [AB#114]

The following recommendations concerning gathering and presentation of evidence in court proceedings by protective caseworkers: To avoid hearing evidence, the protective worker should work with the family long enough to be able to testify himself as to environmental and psychological conditions in the home via expert observations. Competent witnesses, and details as to date, time, and locations of injuries, are information for court processes. Reports of conversations with parents admitting their neglect are useful. Be thoroughly prepared with all the true evidence that can be mustered – school records showing tardiness, poor medical records, other social agency reports on the family.

(58)Child Welfare League of America, n. 56 *supra*.

"Legal separation of children from their families can be carried out only by court order. When a child requires care away from parents or custodian, court action should be taken as soon as possible."

(59)Fraser, n. 55 *supra*.

A guardian ad litem should be appointed to represent the child in any legal proceeding, to make a factual investigation, have access to information concerning the child, introduce evidence and witnesses, and examine any witness who testified, in order to protect the long-range interests of the child. The role may parallel that of *amicus curiae*, with the opinion being advisory to a disposition.

(60)Besherov, see Section I.A., n. 29 *supra*.

"In child protection proceedings, where the child's interests are also at stake, the preponderance of evidence standard appears to be constitutionally sufficient because the need to protect these helpless children and the difficulty of obtaining evidence justify and require this lesser standard of proof."

(61)Joseph Goldstein, Anna Freud, and Albert J. Solnit, *Beyond the Best Interests of the Child* (New York: Macmillan, 1973). [AB#57]

". . .the limitations of law often go unacknowledged in discussions about child placement. Too frequently there is attributed to law and its agents a magical power—a power to do what is far beyond its means. While the law may claim to establish relationships, it can in fact do little more than give them recognition and provide an opportunity for them to develop. The law, so far as specific individual relationships are concerned, is a relatively crude instrument."

"Some of the implications are. . .that each child placement be final and unconditional and that pending final placement a child must not be shifted to accord with each tentative decision."

(62)The family's cooperation is usually an explicit factor in the protective service worker's agency decision to petition for removal. Once the agency has stated before the court that they can't work with the family, the court is left with whatever alternatives exist, of which removal is often the only one.

(63)Shirl E. Fay, "The Social Worker's Use of the Court," *Child Abuse: Intervention and Treatment*, Nancy B. Ebeling and Deborah A. Hills, eds. (Acton, Massachusetts: Publishing Sciences Group, 1975). [AB#51]

"Making a decision to use the courts to help a family is an extremely serious one. It demands a careful evaluation of the total family situation and a diagnostic assessment of the family members (including their ability to make changes). . .It is sometimes very difficult after working for improvements with a family for some time to reach a conclusion – and share our concern with the family – that the situation has not improved enough; despite our joint efforts, we are going to ask the court for help."

(64)Henri Christian Raffalli, "The Battered Child - An Overview of a Medical, Legal and Social Problem," *Crime and Delinquency* 16 (1970), p. 139.

"Unless the parent is an outright sociopath, he will rarely, if ever, admit that he has battered his child. Most often, both parents will deny the fact of any battery and maintain an attitude of complete innocence. Sometimes, the denial is a conscious attempt at concealment, but in other cases the reason for it may be psychological repression."

(65)S. Katz, see Section I.A. n. 38 *supra*.

"Unlike adoption. . .foster care is intended to be a temporary measure – a hiatus in the total relationship of a child with its natural parents which leaves the legal status of the foster parent and the foster child ambivalent. The intended temporary nature of the foster care should be emphasized. . .Experience has shown that to assume nonperformance in foster care is realistic. Children placed in foster care remain in that status longer than is generally admitted by many placement agencies."

(66)Geiser, see Section I.A. n. 41 *supra*.

"Another point to consider in this case is the lack of any plan for Phillip. No one is working with the mother; she is not eager to have Phillip returned to her care. By default he has remained in foster care for a year and a half. For two-thirds to three quarters of the children in foster care, this is the reality of their existence. There is no plan as to whether and under what circumstances they can return home.

(67)*Ibid*.

"Interestingly enough, how parents feel [about the placement of their children] is related to the reason for the child's placement. Thankfulness was common in parents whose children had been placed because of the mother's physical illness. Guilt and relief were common among the parents when behavior problems of the child were the reason for placement. Anger, on the other hand, is most common in cases where parental abuse and family dysfunction are the reasons for placement."

(68)*Ibid*.

"Being rescued from parental neglect is only the beginning of their troubles. The services provided for these children by the state turn out to be a form of public neglect, an illusion of caring. It takes awhile for the children in care to realize they have been doubly ill-treated. In the meantime, separated from their parents, they sit and try to puzzle out, 'What happened to my parents that I had to leave them?'"

(69)Fanshel, see Section I.A. n. 42 *supra*.

This study reports findings that emerged in the course of a longitudinal study of 624 children entering foster care in New

York City during 1966. Of the 624 children, 407 had been discharged from foster care (i.e., foster home or institution) by the end of four years; caring for these children cost $3,567,672. The 217 still under care had already required an expenditure of $3,636,321. Relevant average costs per child were $8,766 and $16,757. Projections from available figures showed, for example, that for the 161 families where the children were still in care, cost of keeping them to maturity would total $23,652,027! From experience, this is not unlikely to occur. Potential savings through returning children to their own homes or arranging adoption are identified. Besides waste of children's lives, financial losses attendant on failure to arrive at prompt case decisions, or endlessly awaiting parental improvement that does not occur are extremely large.

(70)Levin, see Section I.A. n. 55, *supra*.

"Rosen observed that caseworkers who are placed in such unusually powerful roles are likely to symbolically punish or reject parents upon the subconcious reflection of their own personal childhood experiences. What then surfaces is a self-conceptualization as a "rescuer of children" from rejecting parents, a superior parent protecting the victimized child, or an 'avenging angel' acting on the child's behalf."

(71)Katz *et al.*, see Section I.B. n 36 *supra*.

(72)*Ibid*.

(73)Levine, see Section I.A. n. 55 *supra*.

Levine argues that a search warrant should be required to be obtained by child welfare investigator; that parents should be granted and informed of their Fifth Amendment privilege to refuse to answer any questions, should have the right to court review of agency action, and should be granted the right to consult with an attorney *at any stage* of the proceedings.

(74)Fraser, see Section I.A., n. 15, *supra*.

A guardina ad litem should be appointed to represent the child in any legal proceedings, to make a factual investigation, have access to information concerning the child, introduce evidence and witnesses, and examine any witness who testified, in order to protect the long-range interests of the child. The role may parallel that of *amicus curiae*, with the opinion being advisory to a disposition.

Jack L. Smith, "New York's Child Abuse Laws: Inadequacies in the Present Statutory Structure," *Cornell Law Review* 55 (1970), pp. 298-305.

The author examines the problems of coexistence of two statutory laws: Article Three of the Family Court Act (1962) and Article Ten of the same Act, enacted in 1969. Essentially, Article Three is a neglect proceeding whereas Article Ten is more limited in scope for the purpose of protecting children who have suffered physical abuse. They differ procedurally in that under Article Three (the neglect proceeding), the child is represented by a law guardian appointed by the court while under Article Ten, the abused child is represented by a police attorney or assistant district attorney.

(75)Barbara R. Grumet, "The Plaintive Plaintiffs: Victims of the Battered Child Syndrome, *Family Law Quarterly* 4 (1970), pp. 296, 314.

(76)This observation has been made by attorneys representing both parents and children in neglect proceedings, as well as attorneys representing petitioners (welfare departments or city counsel). It should be noted that the attorney for the petitioner and the child's attorney (or guardian ad litem) may well have divergent positions at the dispositional stage; cf. *Report of Select Committee on Child Abuse*, New York State Assembly, Percy B. Buryea, Jr., Speaker (April, 1972), Appendix C., 250, wherein it was observed that law guardians, especially in urban counties, "play a positive watching role during the court proceedings . . . in effect [they] have assumed the role of a second judge . . ."

(77)Robert A. Burt, "Forcing Protection on Children and Their Parents: The Impact of *Wyman v. James*," *Michigan Law Review* 69 (1971), pp. 1259, 1270.

It may be the case that children want to remain with their parents even though they have been maltreated by them.

(78)Goldstein, Freud and Solnit, see Section I.B. n. 61 *supra*.

(79)This, for example is the situation in the Family Court of the District of Columbia.

(80)The source for the accompanying standards is largely from L. Teitelbaum, "Role of Counsel for Private Parties," draft prepared for the Juvenile Justice Standards Project of the Institute of Judicial Administration and the American Bar Association, New York, 1975. (Mimeographed.) The Juvenile Justice Standards Project is supported by grants from the National Institute of Law Enforcement and Criminal Justice, the American Bar Endowment, the Andrew W. Mellon Foundation, the Vincent Astor Foundation, and the Herman Goldman Foundation. The views expressed in the Teitlebaum draft (and the views expressed herein) however, are those of the authors respectively and do not necessarily represent positions of the Juvenile Justice Standards Commission, the sponsoring organizations or the funding sources.

CHAPTER III. MODEL SYSTEM DEVELOPMENT

A. Strategy Concepts for Model System Development

Social intervention technologies are primarily concerned with changing *individuals* or *institutional system*. In order to impact on the handling (i.e., identification, intake, diagnosis, treatment, legal processing, etc.) of individual child abuse cases, in our judgment, aspects of the organization or structure and deployment of institutional resources (e.g., lay enforcement, social, medical, judicial, *et al.*) needs to be changed. At the same time, education of citizens and professionals is needed which focuses discussion on why these institutional functions and resources need to be changed and strategy alternatives for change.

It is a truism to state that it is hard to plan and perhaps even harder to coordinate in human service areas. The need for and difficulties of both planning and coordination becomes very evident just from an assessment of the kinds of data available (and *not* available) in the areas of child mistreatment. From our field visits and a review of the literature on child abuse, it is apparent that most of the valid and important questions on the phenomena of child abuse lack data-based answers. For example, one of the frequent criticisms of foster placement of abused children is that (some, a few, many?) children are battered while in placement and that (some, many?) do not work out in their foster homes and are replaced, replaced and replaced again. But nobody seems to have data on the extent of this serious problem, while a great deal of energy is invested in (or wasted by) disagreement about what is actually happening.

Clearly there is widespread "slippage" in child welfare data—and in what's happening to battered children in child protective agencies, hospitals or wherever complaints or reports on victims are handled. Planning may not resolve these "slippage" problems but at least we ought to be able to have a better grasp of the margin of error involved and its potential implications for the existing intervention system. Without such information, priorities are set by the workings of existing institutions responding to day-to-day pressures.

Development of the model system does not require full information and agreement by everybody about everything. Rather, more attention in planning has to be given to "first approximation of a *re*conceptualized problem". By looking at the problem differently, in a systemic context, goals can be developed to which some numbers can be assigned (i.e., how things were *then*, how things are *now*, and how thing should be *next year*). A commitment to looking at problems in child abuse handling differently and using the limited available knowledge base more imaginatively (i.e., systems analysis) to develop priorities for change may be the most difficult obstacle to overcome in the model system development process, next to achieving system-wide accountability (see Chapter VII, Part 2). Our approach to systems analysis and accountability, as discussed previously, really focuses on the consequences (i.e., possible and actual outcomes) of the actions of laws, institutions, agencies and professional activities. In our judgment, much of what is wrong with child abuse handling in our society today is that we do not know and, in the past, have not thought enough about the consequences of our actions, and is the result of what we have done perhaps even more than what we have not done. And these problems may well be intensified under future "model" legislation designed to do more of the same—perhaps too well.

Much of this problem of overintervention and related under-conceptualization results from decisions made about people's interests solely on the basis of professional judgments without the participation of those whose lives are affected. This fact is true of human services in general as it is of child abuse. Participation could take the form of involvement in diagnostic or other decision-making affecting them and their children or adequate legal representation in court processes. A third form of participation would be involvement in citizens groups developing service plans and projects related to child abuse. However, the effectiveness of such participation, in planning groups or courtrooms, is contingent on who's listening and their capacity to understand. In turn, the capacity to listen and understand to some extent is a function of education and training as well as experience utilizing such knowledge.

Court process is a classic illustration of the problem. Many abusive parents probably would accept help, but help usually is not readily available. For some, help is available but they are unwilling or unable to accept it. This is where the court is supposed to have a key role—enforced treatment. The court becomes the "super-parent" with the authority to make the abusing parent listen. "If you won't listen to anyone else," the court says, "you'll listen to me, in spite of yourself, because I have the legal authority to make you listen." Since emergency services frequently are not available or not responsive to the abuser's needs in crisis, the court frequently has to intervene because no one else is involved (although the family may be known to a service agency). "Since there is no one else to listen to you," says the court, "you'll have to listen to me."

The tragic irony is that until a child is seriously beaten, maimed, or mutilated, society may not pay attention and then the attention is likely to be coercive state intervention—the worse the case of abuse, the more of that coercive attention becomes available. Data on the consequences of such coercive intervention in child abuse or maltreatment cases is non-existent. It is assumed that the outcome, at least for the child, will be less harmful than the harm that led to the intervention in the first place. We don't actually know whether this is true; have not attempted to find out; and, moreover, currently have no way of holding the court accountable for its actions even if data were available suggesting negative outcomes of the legal intervention process. It is precisely at this point, around the ambiguity of consequences of state actions, that planning, related knowledge base improvement, and different forms of participation of those affected, should come together in a concerted system change or development effort.

The Prescriptive Package emphasizes that strategy development—that is, goals for change and means to achieve such goals—seems to be a missing ingredient for much of the planning in the child abuse area. More protective service resources per se probably is not a realistic or effective answer to the systemic aspect of the problems in (mis)handling child abuse cases. At the possible risk of sounding mechanistic, in this next section we will summarize the central strategic concepts of the Prescriptive Package in a somewhat abstract form, confident at least that by this point readers are more or less familiar with the operational details implicit in these conceptualizations. Our intent is to set the stage for a discussion of educational and training needs for model system development in the concluding chapter.

1. *The "Gatekeeper" Concept.* Currently, depending upon which agency or institution an identified case of suspected abuse initially enters (i.e., "gatekeepers"), the outcome of case flow is likely to be different. The three primary "gatekeepers" of current child abuse handling systems are: hospitals (see Figure A); law enforcement (see Figure B); and protective services (see Figure C).

Figures A, B, and C simplify, without basic distortion, typical suspected child abuse case flows. Cases enter the gatekeeper agency on a legal track or quickly move onto a legal track by virtue of the agency's intervention, or enter on a non-legal track; within the agency, the case may move onto a legal track, in the instance of protective services; or upon exiting, the case will move onto a legal or non-legal track.

Tracking—legal and non-legal—is the central dynamic of child abuse handling systems or non-systems and what we term "gatekeepers" are the key institutional mechanisms for tracking. Changing primary "gatekeepers" and the entry/exit processes in the child abuse handling system is the pivotal change in the organization and deployment of institutional resources required to: (1) minimize unnecessary legal tracking of suspected child abuse cases and its often detrimental consequences; and (2) minimize coercive decision-making that infringes on the rights and civil liberties of the families involved.

Entry processes occur both outside and within the "gatekeeper's" domain of control, whereas exiting processes are much more within the "gatekeeper's control. A strategy element of the model system is to minimize use of the legal track at entry so that the suspected abuse case arrives within the "gatekeeper's" domain with the minimum of legal encumbrances on the decision-making process leading up to exiting. Another strategy element is to foster open access for appropriate cases without inducing overload of the "gatekeeper." This necessitates a prescreening mechanism which ideologically and institutionally

FIGURE A

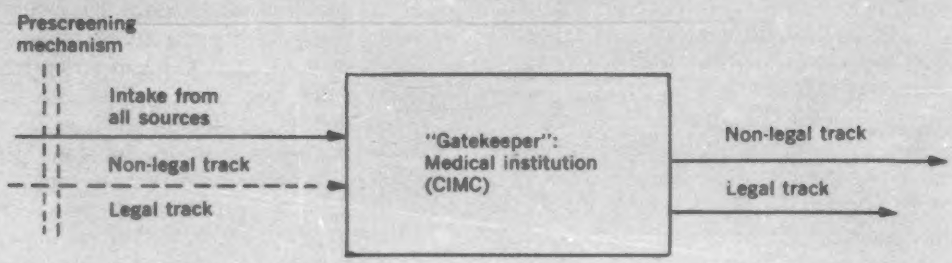

Prescreening mechanism
Intake from all sources
Non-legal track
Legal track
"Gatekeeper": Medical institution (CIMC)
Non-legal track
Legal track

FIGURE B

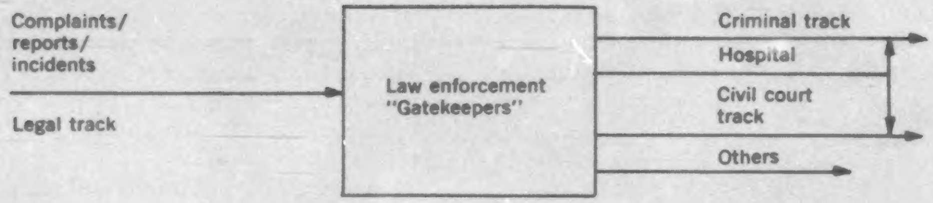
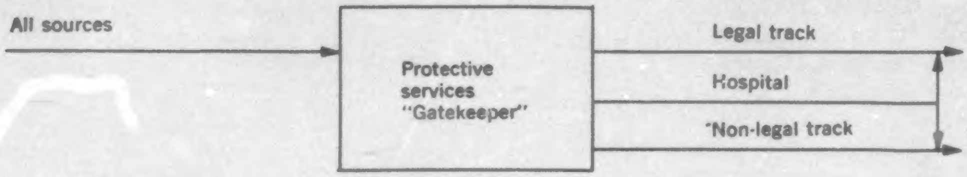

Complaints/ reports/ incidents
Legal track
Law enforcement "Gatekeepers"
Criminal track
Hospital
Civil court track
Others

FIGURE C


All sources
Protective services "Gatekeeper"
Legal track
Hospital
Non-legal track

is as separate as possible from the legal track and whose behavior and functioning complements that of the "gatekeeper."

The strategy of the model system for handling child abuse is developed around medical institutions (CIMC's) as the primary "gatekeepers" and public health agencies (ICEU's) as the primary screening mechanisms (see Figure A). Model system development involves the numerous decisions and other activities of legislatures, public and private agencies, described in this Prescriptive Package, to shift the primary screening and "gatekeeping" functions and responsibilities to ICEU's and CIMC's. Law enforcement agencies would retain, and improve, a vital role in the entry process of the model system, and protective service would retain a key role in the exiting process from the "gatekeeping" mechanism.

Chart II presents the attributes of the "gatekeeper's" behavior and functioning in relation to the seven "events" describing access to the unit of the system functioning as "gatekeeper" (Events 1-3), intra-unit handling of the case type (Events 4 and 5), and exit/follow-up (Events 6 and 7). From Chart A it can be seen that the model system assumes that the system unit functioning in the key

CHART II. Attributes of "Gatekeeper's" Behavior and Functioning

Events	*Decision Choices*	*Determinants of Decisions*
1. Who enters (and does *not* enter) system unit (e.g., everyone, case type)	No	- Law and regulations - Precipitating event - Service System configuration - Institutional professional tradition/ethics - Case type - Institutional resources - Public attitudes
2. Role definition of person entering system unit (e.g., "patient" "client", participant)	No	- Institutional type and tradition
3. How person enters system unit (e.g., coercively/non-coercively, episodically)	No	- Law - Case type (e.g., injury) - Institutional organization
4. What happens (and does *not* happen) to person after entering system unit (e.g., diagnosis, processing, treatment, hearing)	No	- Law - Case type - Standards - Institutional tradition/ethics - Technologies available - Professional roles and ethics - Institutional tradition, organization, procedures, and practices
5. Who does (and does *not* do) what to the person entering the system unit (e.g., diagnose, treat, refer, interview)	No	- Law - Case type - Standards - Professional ethics - Technologies available - Institutional procedures and practices
6. How does person exit system unit (e.g., legal track, non-legal track, combination)	Yes/No	- Law - Case type - Service system configuration - Institutional procedures and practices - Public attitudes
7. System unit role in case follow-up	Yes/No	- Law - Case type - Institutional traditions and practices - Institutional resources - Service system configuration

role of primary "gatekeeper"—the Child Injury Medical Center—has no real decision options with respect to its internal or external behavior and functioning from Events 1-5, or from system unit entry to exit, and only limited, albeit significant, decision choices in Events 6 and 7, exit, and follow-up.

Up to the point of client exit and system follow-up, decisions are determined by laws and regulations, model system and institutional standards and organization, professional roles, standards and ethics, case type, event(s) precipitating the case, community service configuration, system unit traditions, practices and procedures, system unit resources, public attitudes, etc. The principal exiting decisions open to the CIMC as "gatekeeper" are: does the patient and family, i.e., suspected abuse case, leave the medical institution on the legal track or on the non-legal track; at what point in the post-diagnostic process; and with what protections from reinjury and resources for normal development. In other words, the CIMC is licensed by the state to follow prescribed standards and procedures, to exit a suspected abuse case on the legal or non-legal track. Under the model system, the case of suspected abuse, in most instances, arrived on a non-legal track at the gateway to the legal/non-legal tracks.

The professional and institutional credentials and status of the medical institution "gatekeepers" enable them to exercise more discretion with respect to exiting and tracking decisions than any other community institution or agency and to do so on an institutional parity, in terms of real "adjudicatory" and "dispositional" authority and power, with the civil court. In effect, a strategy of the model system is to take the calculated risk of *further empowering medical institutions in the arena of child abuse decision-making in order to enhance their "countervailing power" in relation to the justice system.* In basic political and institutional terms, this strategy is a major aim of model system development. The medical institution becomes the fulcrum for system change, in tandem with public health services, while protective services maintains overall case management responsibility, which requires relatively little system change but will require substantial additional resources for CIMC and ICEU emergency screening and services. Likewise proposed changes in the behaviors and functions of law enforcement officers require relatively little system change. Deemphasis of criminal prosecution of child abuse cases in communities where it may be excessive requires no new legislation and only a minimal addition of new resources for specialized juvenile units or police training activities.

2. *The "guardianship" concept.* An extraordinarily complex array of laws, institutions and agencies, regulations and practices, professional specializations and subspecializations, information transfer and processing activities, etc. are involved with the problem of child abuse. What is mindboggling about this maze of systems or non-systems for the citizen of average intelligence surely is confounding and, moreso, frightening for the families actually involved. The endangered child certainly needs protection when there is a substantial likelihood that he/she will suffer serious harm. However, both parent and child need protection from possible harm in the process of intervention that can only come from two general types of "guardianship": (1) systemic, in which laws and institutions or agencies and systems are constrained from behaviors and functioning potentially injurious to the family life involved; and (2) individual, in the form of adequate legal and lay advocacy for the interests of the child and the parents prior to and during any legal process.

a. *Legal safeguards.* Laws structure and sanction the system of state intervention along a continuum of non-coercive to coercive activities. When the grounds for coercive intervention are broad and vague, and premised on parental fault and misconduct, the system will operate with tendencies toward overintervention and punitiveness, neither of which necessarily serve to protect endangered children from harm.

When laws are specifically focused on a child's injuries and reducing risks to the child within its home environment, the system of state intervention tends to be constained and less punitive.

Narrowing and specifying the grounds for state intervention in child abuse establishes a systemic "guardianship" for children's and parental rights.

Legal representation for parent and child and advocacy for the child in the form of a guardian ad litem, at the earliest feasible point in the decision-making process leading to possible legal tracking and child removal, provides *individualized "guardianship."*

Both forms of systemic and individualized "guardianship" are proposed in the model system.

b. *Information safeguards.* Reporting laws are intended to generate reports and information about the personal history and characteristics of "wrong-doers," in this case suspected abusive parents. Reports tend to generate a surplus of information about individuals in relation to a scarcity of institutional capacity to utilize the information. The quantity and type of information generated by reporters and retained by report recipients is so potentially dangerous to the individuals, and even to the agencies involved, that it has to be treated like poison or radioactive material: segregated areas; scrupulously handled, only by authorized parties; destroyed at specified times; etc.

Arsenals of such "poison" are innocuously called central registers, making no mention of the content or purpose of the material warehoused. Likewise, the persons supplying new raw materials for processing in these information arsenals are blandly called "reporters." Advanced technology has permitted the collection and consolidation of ever greater amounts of data. We are not convinced that any combination of laws and regulations are adequate safeguards for the proliferation of such potentially dangerous materials in state or in national "clearinghouses."*

Consequently, as indicated in Figure D, in the model system we propose to do away with central registers as a key strategy element of "systemic guardianship." Instead of central registers, we propose two completely separated and functionally differentiated information mechanisms: an information system to gather statistics under the provisions of Title XX of the Social Security Act, for the purpose of monitoring performance of the child abuse handling system; and a limited information file, attached to court information management systems, on adjudicated child abuse cases.

B. Education and Training for System Development

The proposed model system provides a means for states and their citizens to reassess the way child abuse is currently handled in relation to the nature of the problem as we know it. This is essentially what Title XX of the Social Security Act asks of states and their communities in relation to the whole gamut of human service needs. This reassessment and planning process can result in more of the same or in strategic redeployment of available resources and reshaping of service delivery systems to accomplish specific objectives. Once these objectives and strategies have been developed, with the fullest possible public participation, the key to successful implementation of the proposed model system and its new roles, intervention processes and procedures, is training of the professionals involved accompanied by education efforts aimed at creating an informed citizenry. Training and education, which conforms to the operational concepts and practices proposed in the model system, also serves the important purpose of facilitating professional and public participation in and support for development of the system. On-going and comprehensive training and education should focus on obtaining feedback for preparation of the annual CASP Plan's provisions for child abuse amelioration, which should be the primary framework for statewide legislative, budgetary, and administrative aspects of system development.

Education and training, therefore, should be designed as a two-way process. For example, in presenting what is known about the handling of child abuse, an attempt should be made to assess the adequacy of the application of what is known in terms of intervention resources or techniques, diagnostic procedures, legal processes, etc. What are the major problems or obstacles in implementing the new system? How are professionals and the public responding to the new system? How are the key agencies in the diagnostic, legal, and treatment process handling their responsibilities? Are the objectives of the child abuse handling system being fulfilled? Which operational problems need to be dealt with first? Is more performance data needed on these problems? Is the Title XX monitoring system providing this data in a usable form?

The model system stresses that cooperation in reporting will depend heavily on professional and public perceptions of the non-punitive, flexible and responsive aspects of the new system and, in particular, the treatment and service help provided to families as an outcome of public intervention and possible legal action. Consequently, lags in service/treatment resource development have to be identified as soon as possible. These gaps in services will have to be translated into specific and realistic objectives for priority service development activities within specific time frames. Thus a special emphasis of education and training needs to be improvement of resource development techniques, e.g., emergency services, related to an ongoing assessment of service needs.

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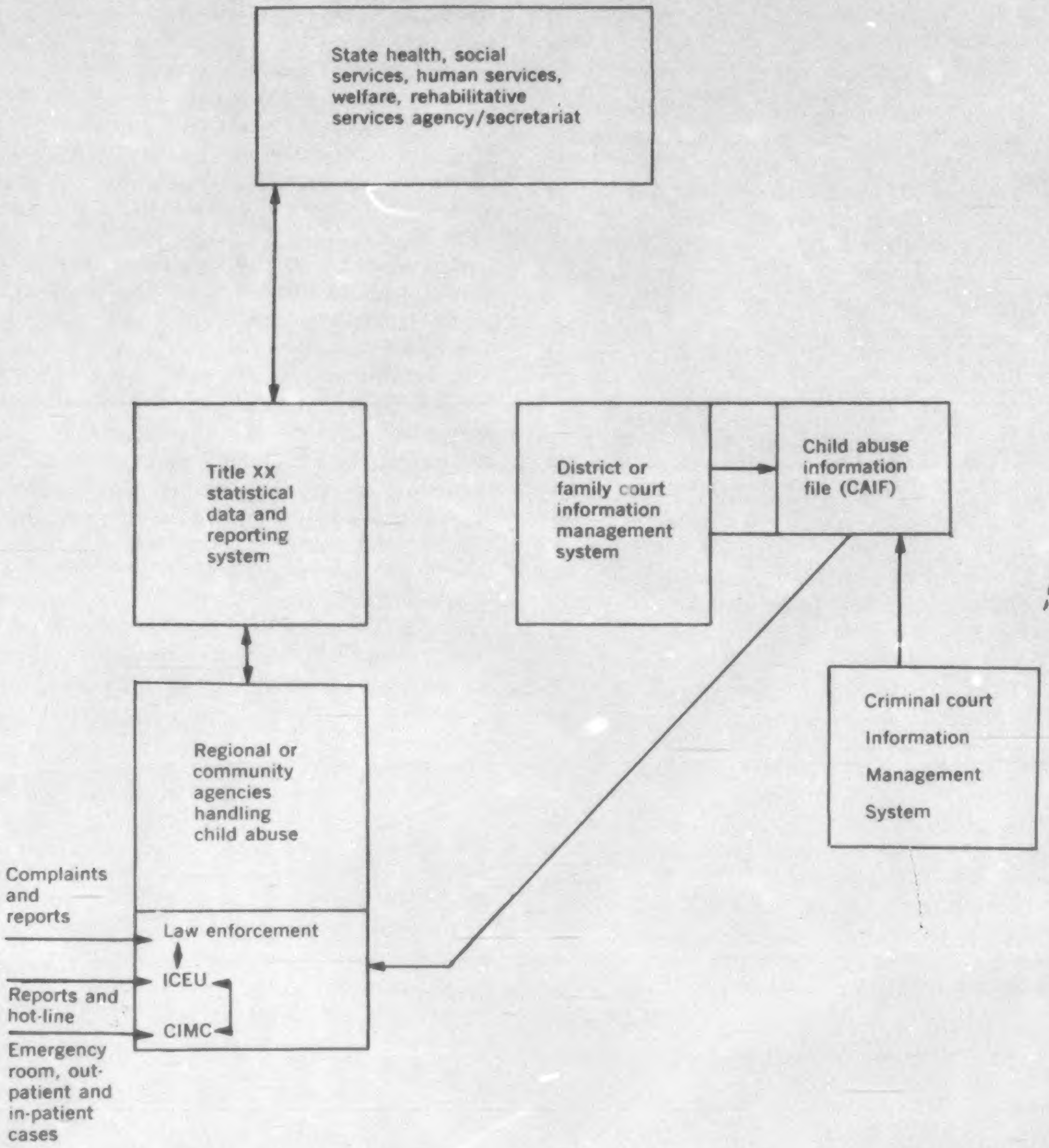
*See Appendix V, which discusses the NCCNA's national data collection system on neglect and abuse.

Alternative Child Abuse Information System

FIGURE D


State health, social services, human services, welfare, rehabilitative services agency/secretariat
Title XX statistical data and reporting system
District or family court information management system
Child abuse information file (CAIF)
Criminal court Information Management System
Regional or community agencies handling child abuse
Law enforcement
ICEU
CIMC
Complaints and reports
Reports and hot-line
Emergency room, out-patient and in-patient cases

It is anticipated that existing federally funded Resource Development projects, several of which focus on hospital-based service models, can be adapted to the requirement of the proposed model. The focus of the hospital-based child abuse unit under the proposed model is shifted, however, from a service and treatment focus to an initial diagnostic function, which still relies on some type of trauma team. Special education would still be required for all hospital staff involved in suspected child abuse cases. Pediatric and legal staff would become more important initially and social work staff less important. Since the primary sources of referrals to designated Child Injury

Medical Centers would be local or sub-regional public health services, the staff of these ICEU's and CIMC's could participate jointly in training sessions to ensure the consistency of their case assessment approaches and coordination of case handling.

Training for protective service workers would focus on case management techniques for coordination of client services and monitoring of client progress. Protective services would also be involved in provision of services. Case management should stress the timely provision of supportive and advocacy services, rather than traditional therapeutic treatment. Advocacy, as the term is used here, means intervention on the client's behalf with other public agencies (i.e., welfare, housing) or with the legal system when a family member is in trouble with the law. Supportive services include obtaining medical care and health services, including family planning counseling; homemaking and babysitting; transportation and emergency funds; day care; individual groups, couples, and law therapy; parent education classes; emergency counseling and sundry forms of crisis intervention. In other words, case management in practice means a person to whom a parent under stress can turn, 24 hours a day, for resources to help meet their needs and that person is responsible for arranging for various combinations of services, follow-up to see how they help, and documenting progress and problems.*

The training of law enforcement officers within the framework of the model system should be an on-going process in each locality. This training should take place in the context of police crisis intervention training. By focusing the legal definition of child abuse on physical injury, and requiring that in every case of suspicious injuries the Injury Child Examination Unit be contacted or, in severe cases, the child be transported to a designated hospital, the police officer's initial tasks are simplified, namely: (a) determining the nature and extent of the problem and (b) referring the possible crisis victim to the appropriate medical institution community service agency.

The model system urges the development of family court divisions within the highest state court of trail jurisdiction to coordinate the judicial interventions into the lives of families involved in child abuse cases (as well as other family-related jurisdiction) and to facilitate the complex and time-consuming process of handling adjudication and disposition for such cases. Adoption of children and its legal antecedents (voluntary or involuntary termination of parental rights), guardianship of minors, and the range of dissolution of marriage issues need to be handled in one family court as well as intra-family criminal offenses (not resulting in death). Perhaps no amount of training of judicial personnel can equal the advantages of a family court division which opens judicial assignment in family matters to the highest status judges of the trial court.

On the other hand, judges handling child abuse (and neglect) cases need to acquire initimate knowledge and first-hand experience of the dynamics and circumstances involved in such cases, which only accompanies longer tenure on the juvenile court bench. One way of overcoming this problem is for judges handling child abuse cases to avail themselves of the professional and agency resources and experience available in their communities or within their state pertaining to child abuse. Frequent contacts with these persons and agencies engaged in providing diagnostic, treatment, and services to abusing families can accelerate the necessary learning process. Where referees are utilized in child abuse cases, as part of on-the-job training, specialized and intensive on-going training, in the community or state-wide child abuse system, should be scheduled for them by the presiding judge.

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*Berkeley Planning Associates is preparing a "Handbook for Implementing Community-Wide Child Abuse and Neglect Service Programs" which will provide the content and guidance for developing training programs in case management.

PART 2

OPERATION OF THE MODEL SYSTEM

CHAPTER IV. THE EMERGENCY INTAKE EXAMINATION AND SERVICE PROCESS

There are very few community treatment and helping services available to families with maltreated children. Within the broad scope of maltreatment of children covered under existing neglect and abuse laws, the question becomes one of focusing resources on one of, if not the most, serious forms of injuries to children. The focus of the model system is on provision of emergency access to diagnosis and treatment for battered children. Physical abuse of children is easier to diagnose than some other forms of maltreatment and, in this sense, easier to work with. In other words, we recommend first perfecting that part of the child protective system dealing with battered children, and then expanding from this base of competence and capability into other areas of child maltreatment as public knowledge and resources permit.

The initial "diagnosis" of the child's injury is seen as a medical problem -- and not as child abuse intervention per se, which, unless the injuries are severe and could not have been self-inflicted or accidental, prejudges the parent's fault or responsibility. The injury may be a cry for help that, in the first instance, should be answered by medical treatment and diagnosis of the child while attention also is given to parental support and help. The initial focus of intervention would be a specialized form of medically-oriented crisis intervention service to determine whether the child's injuries require further diagnosis and what type of emergency support services are needed by the parents.

The proposed model system aims to move an injured child as rapidly and as safely as possible into a medical diagnostic process; minimizes legal and quasi-legal judgments about alleged child abuse, particularly by law enforcement and/or protective services, prior to application of these medical diagnostic procedures; minimizes-legal judgments regarding child abuse during the medical diagnostic process; provides protections for the legal rights of parents and child from the initial identification point throughout the official intervention process; and moves the socio-legal decision-making process on alleged child abuse cases into a civil court adjudication process in order to provide due process safeguards and adequate legal representation for all parties.

The final test of the definition and occurrence of child abuse will take place in a court of law under constitutional safeguards. This emphasis on utilization of the juvenile court, as a court where the rule of law prevails, is not the product of naivete or ignorance about the juvenile court of today. Indeed, it may be that until juvenile courts become family court divisions, within the highest state court of general trial jurisdiction, it will not be possible to adequately handle the judicial demands of child abuse (and neglect) cases.

Whether based in urban or in rural areas, the basic organizing concept of child abuse intervention is that of an *emergency child care and protection system*. In urban areas, the proposed system designates the local public health agency as the recipient of all reports of suspected abuse *or child injuries of any type*. A public health nurse or possibly a physician's assistant would immediately respond to the call, accompanied by a police officer in the instance of severe injuries that may require emergency transportation of the child to a hospital or where there is reason to believe that a home visit in response to a report may result in hostile behavior by the person responsible for the child's care. We are assuming that even in semi-rural or rural areas, except perhaps for the most sparsely populated ones, a public health nurse or a paramedical person, attached to a local or multi-county agency, could perform the function of initial screening of injuries for medical treatment or hospital referral.

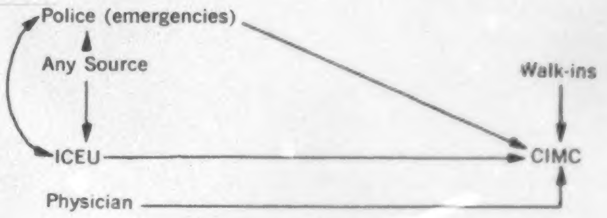
The second component of the crisis child care and protection system would be provision of emergency services to families, with priority for such scarce resources going to families in which there is *suspected abuse of a serious nature* or there is *imminent danger to the life or safety of the child*. In these cases, the child would have been referred for further examination to a hospital facility, with parental consent or under a temporary protective custody order or police hold pending a court hearing, or the child would be placed under court ordered protective custody in the home, with relatives or family friends, or in crisis foster or family day care. Inevitably there will be problems for any nurse or paramedical person, however well trained, in distinguishing some types of cases with respect to the imminence of danger to the child's life or safety. Only sufficient experience with this type of crisis intervention work, supplemented by appropriate training, will enable public health staff to assess family emergency service needs related to abuse.

The third component, wherever possible, would be referral of the injured child to a state-licensed public health clinic, hospital, or other medical facility for medical diagnosis of the injuries. The crisis situation that presumably precipitated a child abuse report (or a hospital emergency room intake) continues to represent an emergency situation, possibly with high risk to the child and certainly a serious emotional strain for the parent, during the diagnostic/verification process. Consequently, the model system aims to give priority status to establishing, wherever feasible, the necessary medical diagnostic resources for injured children in what we call Child Injury Medical Centers (CIMC). Diagram B illustrates the "Basic System Concept" for reporting procedures aimed at ensuring that reports are made by all sources to three types of recipients: police in emergency situations, public health agencies in emergency or other situations, or possibly to hospitals, where injured children also would be brought into emergency rooms or out-patient clinics by parents or other parties.

PRIMARY SYSTEM CONCEPTS

Flow of Suspected or Reported Child Abuse Cases: Identification to the Hospital (Child Injury Medical Center)

DIAGRAM B



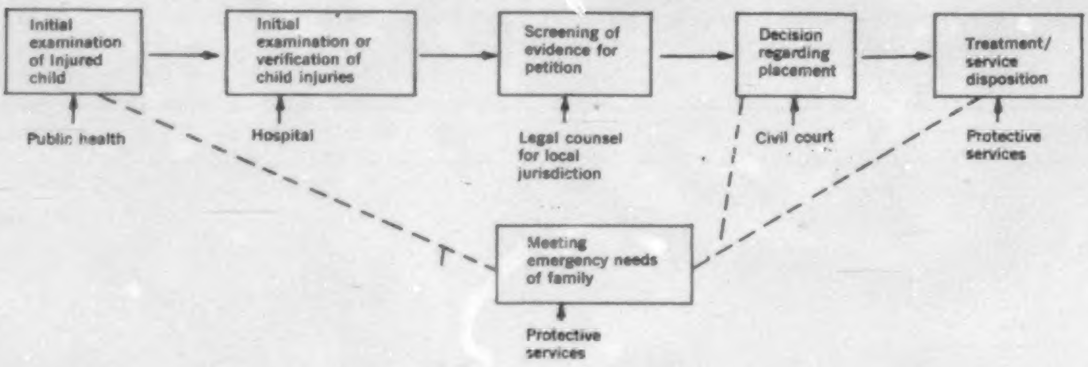
When the police have reason to believe that the child's life or safety is in imminent danger, or the injuries probably are severe, they would respond in the manner used for all types of emergencies, and with full regard for the principles and techniques of family crisis intervention discussed in Chapter V below. In these cases, the police might bring the child directly to a hospital for examination and possibly treatment. Otherwise, the police would contact the public health agency to make an immediate home visit to examine the child for injuries. Depending on the circumstances, the police might accompany (or even precede) the public health nurse in the home visit.

Ideally, the police involved in responses to suspected child abuse cases would be specially trained officers in juvenile units of police departments. The availability of such specially trained police officers of course very much depends on the size of the locality and the resources available to establish these juvenile units.

When a public health nurse or a paramedical person responds to a report or a call from the police they are responsible for making two kinds of decisions: (1) does the child require further examination and possible treatment at the nearest CIMC; and (2) if there is imminent danger to the child's life or safety or if the child requires medical diagnosis in a hospital, does the family unit need some type of emergency services in the presenting crisis situation (See Diagram C).

Selective Concentration of Community Resources at Key Intervention Points

DIAGRAM C


Initial examination of injured child
Public health
Initial examination or verification of child injuries
Hospital
Screening of evidence for petition
Legal counsel for local jurisdiction
Decision regarding placement
Civil court
Treatment/ service disposition
Protective services
Meeting emergency needs of family
Protective services

Again we stress that the purpose of intervention is emergency child care and protection for battered children or children whose lives or safety are endangered. The purpose of intervention is *not* to assess the family's life situation, social or economic needs, behavior or lifestyle, etc. Of course, information on available community resources should be provided to families that need it for them to follow up on a voluntary basis. Moreover, the public health nurse, paramedical worker, law enforcement officer or any other person involved in handling of suspected child abuse cases should be trained to view the suspected abuse situation as follows:

- What are the potential benefits to the child and the family of initiating a referral process for medical verification that could lead to civil or criminal court action?
- What are the potential risks to the child and the family?
- What are the alternatives?

Each of these questions should be asked in relation to the scope of present knowledge about the causes and treatment for child abuse, the capabilities of the local human service, medical and legal system to have positive benefits for the family and child involved, and the posture of the local criminal justice system to treat suspected child abuse as a criminal matter. In the final analysis, the capacity of individual decision-makers to honestly ask and realistically answer these questions will determine the *fundamental fairness* with which the model system or any system operates. We assume that all of the persons responsible for intervening in suspected child abuse cases are motivated by good intentions. Inevitably these good intentions will impel decisions and actions that exceed the boundaries or any reasonable expectations that benefits will result for the child or family involved which outweigh the risks involved.

Consequently, we have assumed that strict adherence to legalisms, such as the conditions under which *Miranda* warnings are appropriate, frequently will lead to violating minimum standards of fairness, while complying with the law and the legal rights of parents and children established by law and Supreme Court or appellate court decisions. Instead, we recommend that each person authorized to make decisions at each point in the model child abuse handling system be required, as a matter of agency policy, to make the following kind of simple and straightforward statement to the parent or other person responsible for the child involved:

> My intention is to help you and the child in every way possible, starting with a medical examination for the child and immediate help for you if you need it. My hope is that these services will only benefit you and the child. But I can't guarantee that. Under our state laws, injuring a child could result in the child being removed from its parents, or even criminal prosecution. I don't want any of those things to happen if at all possible. But I don't control what may happen.

A. The Injured Child Examination Unit (ICEU)

A case of suspected abuse (or neglect) may be initially reported or discovered by a neighbor, a police officer, relative, school teacher, protective services, court, physician, emergency room staff or out-patient clinic, etc. Frequently, the police are the first agency to receive a complaint or a report. With the establishment of a 24-hour, seven-day-a-week hotline to an emergency number, accompanied by adequate public information and education, many initial reports of physical abuse would be selected out of the total calls and referred to the ICEU.

After a report of suspected abuse is called into *any* public agency, police or otherwise, a call would be made to the ICEU for an immediate preliminary examination of the child. In the event that the report pertains to a serious case of abuse, possibly involving emergency removal of the child from the home for hospitalization, the police should be contacted simultaneously to dispatch a police officer to take the child into custody. Under typical circumstances, the ICEU worker would contact the parents by telephone and arrange to make a visit within 2 hours of the referral. If the parent does not consent, the ICEU worker would obtain a warrant for entry into the home, specifically for the purpose of the examination of the child to determine if there are injuries warranting an examination by the CIMC.

If such injuries, as defined below, do exist, the ICEU worker should obtain the parents' permission to transport the child to the designated hospital, with the parent accompanying the worker and the child except in those circumstances where there is a risk to the ICEU worker's safety, in which case other arrangements can be made for the parent to join the child at the hospital. When the parent does not consent to removal of the child to the hospital for examination, the ICEU worker would have to contact the police to have them arrange for a body warrant. For additional details of the entry examination and removal procedure, see Model System Chart I.)

Even when the child's injuries do not qualify for referral for a hospital examination, the ICEU worker may find that the family has immediate needs of other sorts. In such situations, the availability in the community of a "Comprehensive Emergency Service"* (CES) for children and their families would be an invaluable resource for voluntary referral, i.e., informing the family of the availability of services but *not* reporting the family, say, for neglect of other reasons unless the life or safety of the child is imminently endangered or the child's health is significantly impaired.

B. Injuries Qualifying as Potential Abuse

The key question to be answered by the public health nurse or paramedical person is whether there is sufficient evidence of physical injury to the child to warrant removal of the child from the home for examination in the designated hospital facility – the Child Injury Medical Center (CIMC).

Physical abuse is defined in the model system as injuries inflicted by a parent or caretaker. The injuries include bruises, burns, head injuries, fractures, etc. The severity can range from minor bruises, welts and scars to fatal subdural hematomas. The determination of abuse is based on severity of the injury, age of the child, and comparison of the parent's explanation of the injury and its nature. Below are definitions (developed by the Adams County, Colorado, Department of Social Services)* which can be used in classifying severity of injury, all of which are the type of injuries qualifying as potential abuse:

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*See Appendix III (III-I)

*See Appendix III (III-I)

Death due to abuse: Child's death due to non-accidentally inflicted injuries.

Severely injured: Child found to have multiple fractures, head injuries, massive bruises, burns and/or severe hematomas including both old and new injuries.

Moderately injured: Child found to have a single fracture, numerous bruises, a few severe bruises, burns covering small areas of the body, and/or lacerations, with no history of previous injuries.

Physical punishment: Punishment that leads to bruises or injuries requiring medical treatment would qualify as abuse. Lash, laceration, bite, choke, and finger marks are distinctive. The child may have suffered eye damage including acute hyphema, dislocated lens, and detached retina. Burns are commonly inflicted by cigarettes, forming circular, punched-out areas of lesions, usually on the palms or soles. Dry contact (e.g. radiator) and several types of hot water burns are diagnosable. The worst injury in terms of death and also serious after effects is a subdural hematoma. These children often come in to hospitals with coma and convulsions. Some of them have multiple skull fractures secondary to being hit against a wall or door. However, many of these cases have no fracture and the subdural hematoma is due to violent shaking injuries. Intra-abdominal injuries are the second most common cause of death in battered children. These children present symptoms such as recurrent vomiting, abdominal distention, absent bowel sounds, or localized tenderness. The diagnosis of inflicted injury requires a general medical examination supplemented by laboratory data and a "trauma survey." The types of laboratory tests and radiologic examinations required for a diagnosis of inflicted injury are discussed elsewhere. In addition to the nature of the injury itself, many cases of physical abuse are first suspected because of the implausible history that is offered to explain a child's injury.

Unexplained injury - Some parents will be reluctant to elaborate on how the injury might have happened, and others might say they have no idea about it. Some will give a vague explanation such as "He might have fallen down."

Contradictory story - Sometimes there is a discrepancy between the histories offered by the two parents. Another common contradiction occurs between the history offered and the physical findings, such as a history of a minor accident and yet the findings of a major injury.

Bizarre story - The child who is under six months of age is unlikely to induce an accident. A story such as the baby rolled over on his arm and broke it or got his head caught in the crib and fractured it are impossible. Histories of older children who deliberately injure themselves are also usually false.

Delay in seeking medical help - Normal parents come in immediately when their child is injured. Many abused children are not brought into the hospital until the morning after the injury or for a considerable period of time despite a major injury.

In proposing that medical examinations of injuries should be the single primary decision-making arena for diagnostic assessment and possible legal processing, it should be emphatically stated that injuries to children that are caused by abuse are only viewed as symptoms. The problems suffered by families who may have abused children cannot be diagnosed by the injury. Moreover, we do not assume that the severity of the injuries indicates the severity of the family's problems. However, until human services are much more available and accessible to all families, and research more definitively establishes psycho-social "risk indicators," in our judgment a model system should develop medical examination procedures that initially focus on the "effects" of the problem, with full legal safeguards.

The necessary process of exploring and defining these psycho-social "risk indicators" should properly be carried out in the context of well-designed demonstration and research projects, which also have adequate built-in legal safeguards, and not in highly discretionary social investigation processes conducted by protective service agencies or hospitals. Here again we stress that the proposal to severely limit such investigations does not presume that a medical examination of suspected abuse cases suffices to determine a family's need for protective services.

C. The Child Injury Medical Center (CIMC)

A child referred by an ICEU to a hospital with specialists in diagnosis of children's injuries needs care and protection from harm. The parent is in distress as well and needs help. Hospitalization of a suspected battered child amounts to an opportunity for time-limited crisis intervention. Where the model system's proposal for diagnosis of the child's condition differs fundamentally from current diagnostic processes used by many hospitals in dealing with child abuse is in the family evaluation process. Currently, such hospitalization includes efforts at in-depth assessment of the family situation while the child is hospitalized and being medically diagnosed and treated. The parents and perhaps other family members are interviewed by the hospital's interdisciplinary trauma team. Community agencies are contacted who have known the family in the past for family history data and participation in development of a treatment plan.

During this process, the trauma team "adjudicates," i.e., diagnoses, the case and decides on an appropriate "disposition." Conceivably, this transferral of the court's role and functions to a hospital setting results in both better "adjudications" and "dispositions." But the fact remains that for all the benign, sophisticated and professional expertise involved, hospitals are using their institutional authority and quasi-legal power to induce or coerce parents into accepting their "adjudication" and "disposition" of the case, under threat of court action, while the child is "incarcerated," i.e., hospitalized. The parent or caretaker does not receive a due process hearing with legal representation and constitutional protections.

Furthermore, the family unit is thoroughly investigated as part of the hospital's fact-finding process without recourse to defense counsel using discovery procedures, witnesses, or usually even access to the professional "jury" weighing the evidence. If and when the case finally does have its day in court, the collective weight of the professional credentials and status of the multi-disciplinary team, combined with the typical judge's relative inexperience with child abuse, probably guarantees that the verdict and disposition will have been made in a hospital conference room.

The aim of the model system is to fully utilize and, at public expense, develop the capabilities of designated hospitals for medical diagnosis of suspected child abuse cases, but not to institutionalize (highly discretionary) decision-making responsibilities in hospital conference rooms that more appropriately belong in courtrooms subject to the test of adversarial proceedings. Otherwise, the potential hazards of discretionary and coercive protective service decision-making, about which concern was expressed in a previous section, simply might be transferred to and possibly magnified in an institutional setting that is even less accessible to public scrutiny and has an undistinguished record of accountability and responsiveness to the public.

With these important caveats in mind, the key diagnostic decision to be made by the CIMC is whether or not, from medical evidence, it appears that the child's injury(s) occurred in a non-accidental manner or the accidental nature of the injury appears seriously questionable. In both instances, the child may be in jeopardy of reinjury and the legal questions of the child's protection, custody and possible placement needs are at issue.

If the child is to be held in the hospital, with or without consent, because abuse is suspected, either a petition would have to be filed or the child should be returned home within a specified maximum period of time, e.g., 96 hours.*

If the injury was determined to be accidental, the child would be returned home as soon as medical treatment was completed. The matter would be dropped, or if the child appeared to be suffering from neglect, abandonment, etc., the hospital could proceed under whatever provisions are established for such cases. The hospital might suggest that the parents voluntarily seek emergency services, but if they don't, no sanctions whatsoever should be imposed.

Every case determined to be non-accidental would be referred to the county/city attorney for a legal determination of whether a petition is warranted. This should occur in every case, whether the child required hospitalization, or removal from the home, or not.

In short, initially in cases of suspected abuse, the hospital performs only a *medical diagnostic* function, to decide if the case appears to be accidental injury or not. Once the medical aspects of the accidental/non-accidental issue are resolved, *as best they can be* at the hospital, the case would either then be referred to the county/city attorney for further determination of appropriate legal action or the matter would be dropped. No *conditions would attach to either decision.*

Where there is a need to hold the child in the hospital beyond an initial period of 24 hours from emergency entry into the CIMC (for further examination) or elsewhere (for protection), a court order must be first obtained if the parents do not consent. However, contrary to the general practice, notice of the application for a Temporary

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*An initial period of emegency temporary custody (48 hours) plus a court-authorized extension of custody (48 hours).

Protective Restraining Order (TPRO) should be required to be given to the parents so that they can be present. Their presence is desired because it should be at this point that the parents are assigned counsel. This TPRO, if granted, should be limited to a 48-hour period. One extension for an additional 48-hour period may be granted after motion and hearing. If a longer hold on a child is necessary, an abuse (or neglect) petition would have to be filed with an attached motion for an extension of temporary custody (where a TPRO was previously granted) or with a motion for the granting of temporary custody (where no order has previously been entered).

In every case entering the CIMC where child abuse is suspected or diagnosed, the parent or caretaker would immediately be informed of the law, the procedure to be followed in the CIMC, including the CIMC's authority to hold the child for 48 hours, and the possibility of subsequent legal action. The parents or caretakers would be urged and assisted to obtain counsel as soon as case evaluation suggests the possibility of suspected abuse.

A particular focus of the proposed hospital-based child abuse screening process is to minimize misclassification of injuries which, for the white and relatively well-educated population, results in a prevalence of "accidental" injuries while among non-white, lower-educated population results in a much higher proportion of "non-accidental" injuries. Both types of families might fall into the "high risk" category but white families tend to be disproportionately perceived as "unable to protect their child from hazards of their environment" while non-white families more often are perceived as abusive parents.

Rather than simply interpreting this different pattern of child injuries related to race as the result of 'differences in adapting to high levels of stress,' our proposed system establishes procedural and legal safeguards aimed at preventing inequities of classification among "high risk" families. This does not mean that any system can be designed to compel physicians in hospitals to diagnose "accidental injury" cases, especially in-patient cases, so as to eliminate bias related to the race of the patients. Realistically, at best non-white patients suspected of abuse, especially those using emergency rooms and other out-patient services, need to be protected from premature and inappropriate misclassification.

Any striking disparities in hospital classification of cases as "accidental" or "non-accidental" related to race will have to be dealt with as a matter of hospital policy and systematic monitoring of outpatient and inpatient data pertaining to cases that qualify for child abuse screening. This means that the hospital-based multi-disciplinary team concerned with screening child abuse cases has to have sufficient administrative and professional support to ensure that screening criteria and procedures are applied by physicians uniformly and equitably to all outpatient and inpatient cases where the chief complaints qualify for child abuse screening.

Screening cases in hospitals with emergency room/outpatient clinics still will result in a great deal of discrimination in communities where child injury cases in more affluent (white) families will be handled by private hospitals and clinics and thus will not be subjected to child abuse screening. In other words, under the proposed system, poor children's injuries are still more likely to be detected, diagnosed as signs of child abuse and reported to authorities. In this respect, our proposed system -- and any system -- will be basically defective and discriminatory in process and outcome.

Finally, from the standpoint of the realities of the lives of both white and non-white families, of any income and education levels, isolation of child abuse may make even less sense than from an etiological standpoint, especially when the methodology of intervention is grounded in the concept of intentionally perpetrated injury. However, until we have a more precise definition of the processes of cause and effect resulting in child abuse, the behavioral and environmental dimensions of the problem, we have opted to focus on physical symptoms for screening risk for recurrence of child abuse. Hence the system is designed around the following logic:

- A child is discovered to be moderately or seriously injured.
- The injury, in the best judgment of medical professionals, probably was not caused accidentally.
- The child may be at risk for reinjury, perhaps even more serious.
- This risk has to be minimized.
- At the same time, the civil liberties and rights of parent or caretaker and the child have to be protected.

The key questions become: how much intervention is necessary to deal with the causes of possible parent/caretaker dysfunction, resulting in abuse; and how can the appropriate intervention accomplish its aim -- "protection" -- with the minimum of disruption and intrusion.

The proposed model system assumes a continuation of private physician underreporting for the foreseeable future. Hopefully, physicians increasingly will refer cases to CIMC's for medical diagnosis. Likewise, over time interhospital transfers to CIMC's are expected to increase as cooperative procedures are developed. Consequently, an increasing diagnostic workload will become the responsibility of CIMC's, requiring adequate federal-state financing of the personnel and other costs required for the diagnostic process. It is envisioned that the proposed CIMC's would develop from existing federally-funded hospital-based multi-disciplinary team projects in numerous metropolitan areas. An equivalent diagnostic resource to semi-rural and rural parts of the country probably would require alternative models for diagnostic and service delivery functions.

Physicians are reluctant to testify in court.(2) They don't understand the workings of courts. They are concerned about the amount of time that may be consumed in court hearing, and subjection to interrogation by one or more lawyers about their diagnoses. The amount of time spent with an abused child and/or parent during and after the diagnostic process can be considerable and costly. Usually, there are few personal or professional rewards in dealing with abusive parents and at the end of the process of legal intervention is a community service system that generally works poorly for its clients.(3)

No doubt additional training for all physicians, while in residency, in the complex area of child abuse and neglect, might improve to some degree the cooperation of physicians in reporting and following up on child abuse.(4) However, within the context of existing child systems across the nation, there is not much reason to be overly optimistic about the potential results of more effective training, at least in the short-term. It has been suggested by Dr. Ray E. Helfer that of more practical impact would be the training of pediatric specialists in the area of child abuse who would work, on a subsidized basis, in a hospital-based, multi-disciplinary child protection team.(5) Dr. Helfer has proposed special training programs in child abuse and neglect for pediatricians that include "course work in early childhood development, the acquiring of interpersonal skills and counseling methods, extensive experience with the effects that trauma have upon the growing child and, finally, methods of implementing change within his or her community."

The proposed model system depends very heavily on the diagnostic judgments of pediatric specialists in licensed Child Injury Medical Centers utilizing multi-disciplinary teams. The amount of time spent by pediatric specialists in performing necessary diagnostic procedures, participating in frequently lengthy case discussions with other professionals and, as required, with the child and his/her family, precludes reliance on a fee-for-service arrangement.(6) The pediatric specialist involved in child abuse cases must be salaried. Under the proposed model system, depending on the population size of the CIMC's service area and the actual and/or projected volume of suspected abuse cases referred annually for diagnosis, at least one or two pediatric specialists would have to be salaried on a full-time or part-time basis as members of child protection teams. The pediatric specialist is crucial at both the diagnostic stage of handling suspected child abuse cases, i.e., pre-petition, and in the treatment phase, subsequent to appropriate court action or a decision by the CIMC not to refer a case for court action.

In particular, cases which meet the established criteria for referral to the local jurisdiction's attorney for a petition, including possible removal of the child from its parents or guardians, necessitate the availability of an elite group of professionals and para-professionals -- a child protection team(7) -- to ensure that, at the very least, the child that is *not* separated from its parents or guardians is in fact protected from further harm while the family unit is subject to what may be a protected court process.(8) The situation that precipitated a child abuse report or hospital emergency room intake still represents a high-risk emergency situation during and after diagnostic and legal intervention. Consequently, the model system proposes to give priority status to battered children as a category of child welfare problems that should be protected from the consequences of such typical problems in the helping professions as scarcity of manpower (especially trained manpower), inadequate emergency resources, communication breakdowns, inter- and intra-professional conflicts, etc.

In hospitals which have developed child abuse teams or trauma units, as indicated above, these teams usually include social workers, psychiatric nurses, psychiatrists, and psychologists in addition to the core medical personnel (pediatricians, other medical specialists, and nurses). Team case conferences often include representatives from other community agencies (protective service, public welfare, probation, mental health facilities), and records from a variety of sources (schools, police, private social service, etc.) in addition to the records of agencies present at the conference.

In view of the importance of decisions made at these conferences -- whether to file a neglect or dependency petition in court, recommendations to be presented at the dispositional stage, the nature of services to be "offered" for "voluntary" acceptance by parents -- it is suggested that in effect these case conferences essentially function as a "pre-trial" of a possible neglect or dependency case. It would seem appropriate, therefore, that a representative of the interests of the parents, whose behavior and future alternatives are being discussed, should participate in the proceedings. While this might introduce a "chilling" effect on the free exchange of information among the members of the case conference team, this restraint on the exchange of information is likely to be in the direction of excluding irrelevant or unsubstantiated "impressions" which should not properly influence decisions in any event.

There are several possible forms of parent representation which might serve to ensure that the interests of the parents are adequately articulated in these trauma team sessions. One is the inclusion of a "parent peer" -- possibly a member of an organization such as Parents Anonymous who has experienced child abuse handling situations and proceedings, inside or outside of the legal system, and who can closely identify with the position, concerns, and interests of parents in such situations. However, there is the possibility that such lay parent peers, in a meeting of professionals who may have had -- or may in the future have -- the authority and power to intervene in the peer parent's family life, may be less than an effective participant in the case conference and may even become a token member of the team.

A professional of equal stature with those making decisions at the team conferences -- such as an attorney representing parents individually or all parents, as a class, before such groups -- might more effectively represent the concerns and interests of parents. It should be noted that, under the model system, CIMC trauma team diagnostic case conferences are *not* proposed to include outside agency representatives, and the initial diagnostic decisions to be made are limited to whether or not to refer a case to the city/county attorney for petitioning and what types of emergency services might be beneficial to the family during the crisis period.

For existing trauma unit programs, undoubtedly this proposed limitation on decision-making probably is the most controversial and objectionable from the standpoint of professional philosophies and operational procedures. The hospital-based trauma units, such as the Trauma X group at Children's Hospital in Boston, see their diagnostic function as developing insight, from interdisciplinary and interagency sources, into the causes of a particular child's injury and, as early as possible in the diagnostic process, to attempt to ameliorate the underlying familial problems. The diagnostic process leads to medical, service advocacy and counseling services provided by the interdisciplinary trauma units in conjunction with work done by community family service and protective service agencies.

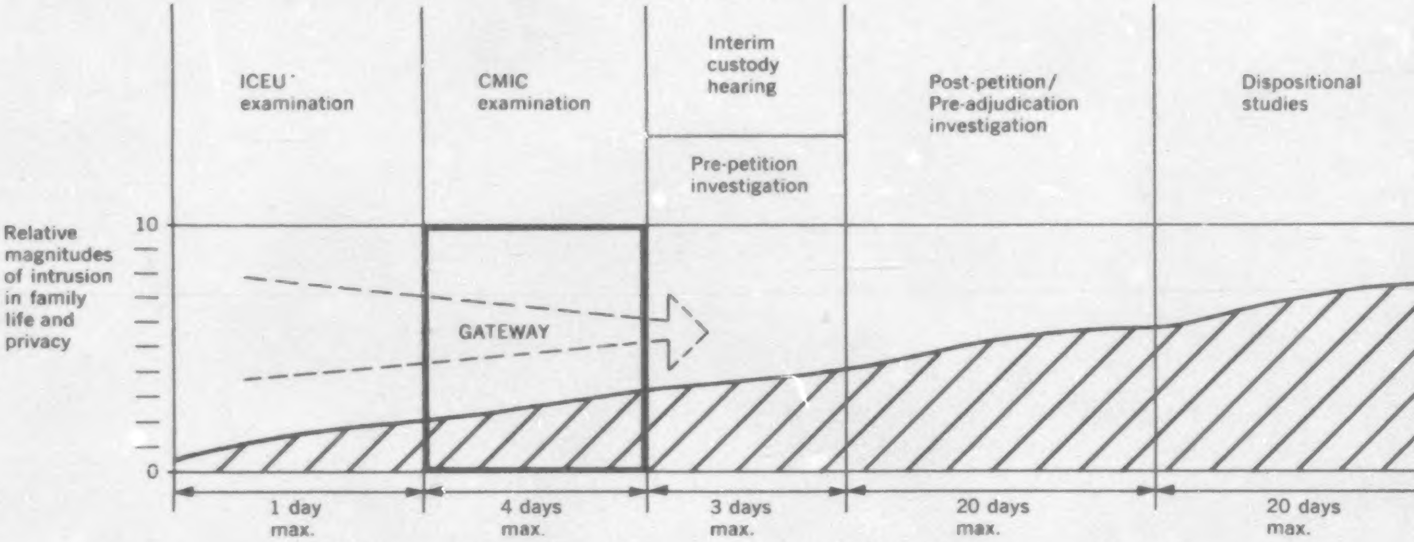
It should be stressed that the full range of multi-disciplinary treatment and service efforts are fully compatible with the proposed model system, but only after the CIMC's have performed a narrower "gatekeeper" function, i.e., to make the decision as to whether it appears necessary to resort to referral of a case for the filing of a petition in civil court. In other words, as discussed in Part 1, Chapter III.A., the strategy of the model system places a heavy ethical, diagnostic and legal responsibility with medical professionals as "gate keepers" to the court system in terms of decisions as to whether or not a court adjudication process is necessary to enable a child's home to be a safer context for child growth.

As will be discussed more fully in Chapter VI, Civil Adjudication Strategy and Process, the kind, amount and degree of intrusion in family life and privacy during the CIMC examination process is constrained, at least initially, to medical diagnosis until the family has the full due process protections of a properly conducted sequence of civil court proceedings which increase the amount of family and personal information available to decision-makers (see Chapter IX, Part 3). The full capabilities of the CIMC trauma team would not be utilized until post-petition stages of the civil court process (see Figure E) or until a decision had been made by the CIMC or the city/county attorney not to proceed with a petition.

STAGES OF THE EXAMINATION, INVESTIGATION AND JUDICIAL PROCESS

FIGURE E

Relative Magnitudes of Intrusion in Family Life and Privacy at Various Stages of the Examination, Investigation and Judicial Process



ESTIGATION AND JUDICIAL PROCESS

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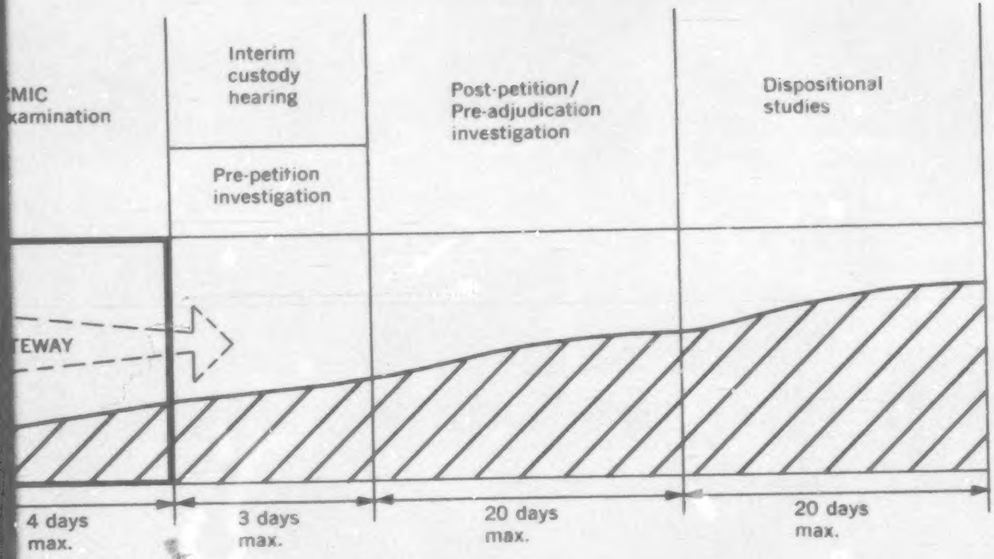

Admittedly, this decision-making responsibility placed in medical institutional contexts is proposed with cautious optimism. The success of such hospital-based programs for the diagnosis and management of child abuse will depend on development of effective interdisciplinary case management decision-making processes which are fully attuned to the purposes and techniques of handling the "gatekeeper's" complex role.

The most important factors which limit effective interdisciplinary action for child abuse victims and their families are summarized by Dr. Eli Newberger as follows:(9)

- *Lack of understanding by the members of one discipline of the objectives, standards, conceptual bases, and ethics of the others.* For example, physicians in hospitals often see social workers' professional activities in terms of referring patients to foster homes and carrying on the unpleasant--if necessary--day-to-day contacts with families for whom they have little time.
- *Lack of effective communication from members of one discipline to members of another.* Possible examples include the important child-development observations that nurses frequently make which, for want of not having been heard, are ignored in the process of diagnostic formulation and decision making by social workers and physicians.
- *Confusion as to which personnel can take what management responsibilities at what times.* In a hospital, for example, the doctor is accustomed to thinking that he is the boss; he alone decides when the patient is admitted or discharged--perhaps only on the basis of medical criteria. Upon the child's discharge, he may expect that the protective service's social worker will obediently knock on his patient's family door, hat in hand, to ask, "Have you been beating your child?"
- *Professional chauvinism.* A sense of professional pride may lead a social worker in a private family service agency to tell a colleague in a public agency or a public health nurse or physician, "Look, we've been in this business a hundred years. Who do you think you are to ask if we made a home visit last week?"
- *Too much work for everybody, and a sense of hopelessness and despair in the face of overwhelming problems and unsympathetic colleagues.* This factor probably accounts for the large yearly turnover of social work personnel in public agencies--with the resulting loss of continuing service to individual families and of precious, experienced manpower. In Massachusetts, the staff turnover in the Division of Family and Children's Services of the Department of Public Welfare ranges up to 30% a year.
- *Institutional relationships which limit effective interprofessional contact.* An example with which I am personnally impressed is that of hospitals competing for patients and prestige. Their professionals staffs (in medicine, social work, and nursing) may be reluctant to communicate with rival institutions' staffs--much less to collaborate with them in providing coordinated services to families whose individual members may receive continuing services at several clinics and offices. Social workers in public protective service programs are often isolated in state departments of public welfare. The other ancillary components of clinical child abuse management are fragmented, in most cases either into separate departments of public health or mental health or in separate private offices.

  The distinguished child psychologist Urie Bronfenbrenner has observed that American service institutions often serve to divide rather than to integrate families.* In child abuse management, we can often see the destructive consequences of separate institutions which attend to various aspects of welfare, health, and child development, but which cannot--because of their organization--work effectively together to strengthen family life.
- *Prevailing punitive attitudes and public policies about child abuse.* Many professionals from outside the field turn away from involvement with protective service workers and programs as a result.
- *A lack of confidence and trust on the part of personnel from one professional toward colleagues in the others.* This problem is made more difficult by the exceeding per-

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*Bronfenbrenner, U. *Two Worlds of Childhood.* New York: Russell Sage Foundation, 1970.

sonal demands on everyone working with families whose children's lives are in jeopardy. The feelings within oneself generated by the anguish, remorse, anger, and guilt, displayed by these families are hard to handle. They prompt serious conflicts among us and try our professionalism enormously.

- *Cultural isolation of professional personnel.* The traditions and values of child rearing and family life among black, Spanish-speaking, or other minority families--who seem disproportionately represented in child abuse case reports--may be ignored by physicians, social workers, policemen, lawyers, and judges, who tend predominantly to be white. Because professional action on child abuse cases nearly always hinges on assessments of family competency, culture-bound value judgments can be harmful. They also promote conflict among professionals of different cultural background.

The proposed model system assumes the continued prevelance of private physician underreporting which results from systematic inadequacies in the organization of health care delivery systems in the United States. In effect, the model system proposes to substitute a specialized tandem of medical personnel -- public health service nurses and hospital-based medical teams -- for the ongoing identification and examination of incipient abuse that would result from universal maternal and child health programs. Presumably within this tandem, the trained nurses, physicians and other medical diagnosticians would be able to establish the kind of professional working relationships and communication processes that would minimize some of the interdisciplinary frictions described by Dr. Newberger.

At the same time, new or intensified sources of friction are bound to emerge, especially between, on the one hand, protective service and social workers in public social services agencies and, on the other hand, public health nurses and hospital physicians who, under the proposed model system, would be preempting the social worker's traditional "turf."(10) However, the intervention strategy of the model system proposes to move the budgetarily limited resources of protective services from the "front-end" of the child abuse handling system, i.e., investigation and verification, to the post-dispositional phase of the system as part of and, perhaps more important, case managers of, the treatment and service teams. In the process, the problematic duality of role of protective service workers, as law enforcement agents and social workers-therapists, may be more feasible of resolution.(11)

An even more important reason for converting the traditional protective service investigation-verification role into a medically-oriented examination process is the prospect of greatly increasing demands on the direct and indirect service time of protective services staff accelerated by state responses to the Child Abuse Prevention and Treatment Act,(12) especially if staffing standards are developed and instituted which are at least realistically based on experience.(13) It is our contention that much of the interdisciplinary tension, conflict and miscommunication in handling child abuse cases probably derives from overloading and turnover of protective service workers.(14)

D. Existing Practices of Hospital Trauma Units

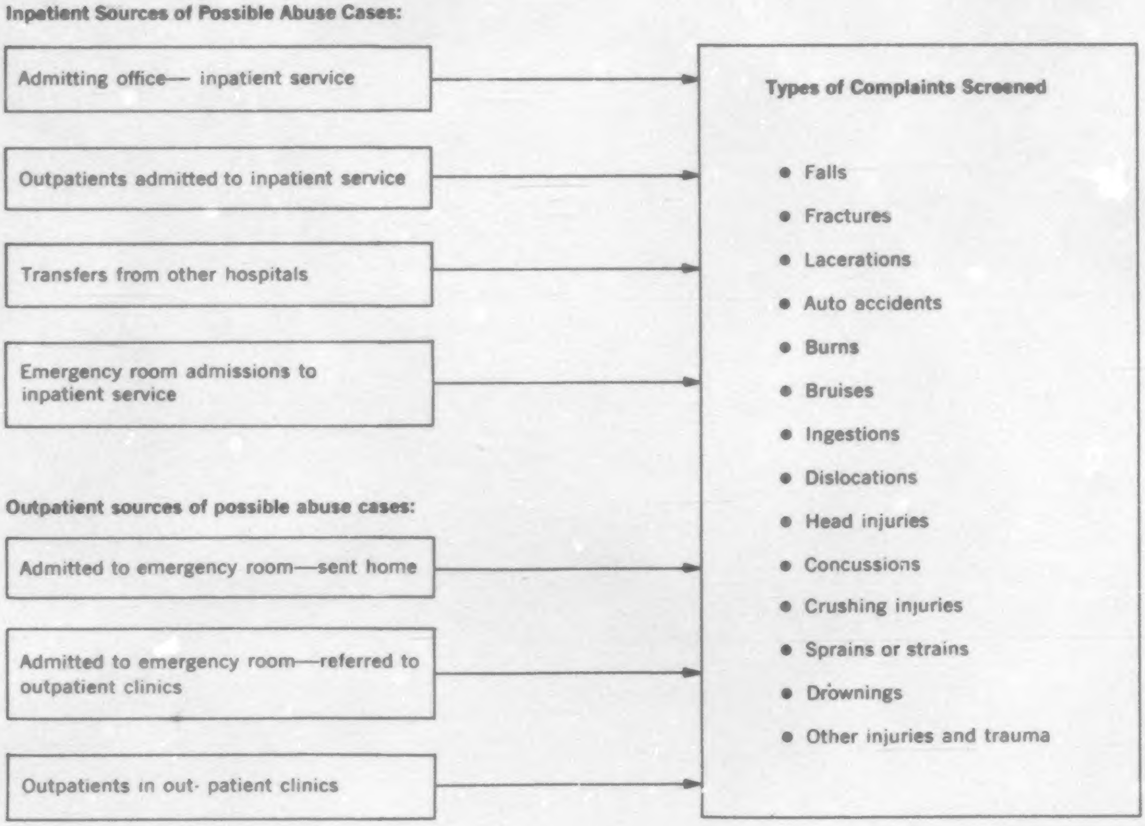
Hospitals vary widely in their handling of suspected inflicted injury depending on the nature of the state law pertaining to abuse (e.g., punitive versus non-punitive); the original referring party (e.g., law enforcement versus social services); the location and size of the hospital (e.g., inner-city urban versus suburban: large public versus small private); the availability of specialized medical-social-psychological teams for diagnosis; and, not least of all, the severity of the suspected abuse case. No mandated institutional or agency reporter has the latitude and discretion for decision-making, especially under strict child abuse reporting statutes, possessed by hospitals.

The more heavily hospital professionals are involved with child abuse and specialized inflicted trauma units, the more they view it as a family unit treatment problem; the more frustrated they feel by the role of law enforcement agencies in removing reported cases from hospital control and in interfering with any treatment modality; the more concerned they are with the tendency of child abuse statutes to focus on separation of the child from the family and most especially concerned about the detrimental psychological consequences of excessively long-term foster care; and the more distressed they become about the amount of time consumed in attending juvenile and criminal court proceedings as witnesses.

When a parent or guardian brings a child to the Emergency Room, outpatient or inpatient service and the physician suspects that the child has sustained non-accidental injuries (see Diagram D for types of complaints screened from various hospital services), the following guidelines generally are utilized by hospital trauma units.

Outpatient and Inpatient Sources of Possible Abuse Cases Referred to Hospital Trauma Units

DIAGRAM D


Inpatient Sources of Possible Abuse Cases:
Admitting office— inpatient service
Outpatients admitted to inpatient service
Transfers from other hospitals
Emergency room admissions to inpatient service
Outpatient sources of possible abuse cases:
Admitted to emergency room—sent home
Admitted to emergency room—referred to outpatient clinics
Outpatients in out- patient clinics
Types of Complaints Screened
Falls
Fractures
Lacerations
Auto accidents
Burns
Bruises
Ingestions
Dislocations
Head injuries
Concussions
Crushing injuries
Sprains or strains
Drownings
Other injuries and trauma

1. *Hospitalization of the suspected case.* The purpose of hospitalization is to protect the child until other evaluations regarding the safety of the home are complete. The extent of injuries is not relevant to this requirement. The reason usually given to parents for hospitalization is that "his injuries need to be watched" or "further studies are needed." The possibility of non-accidental trauma (or underfeeding) is not mentioned at this time. The outpatient physician keeps incriminating questions to a minimum. Serious homicidal threats (e.g., "If I have to spend another minute with that kid, something bad is going to happen.") require admission and psychiatric consultation.

The diagnosis is not always clear-cut and is unpleasant for staff members. However, a consistent approach to these children is found to be most helpful. Histories of the accident include where, how, and when the injury occurred and who inflicted it or may have witnessed the infliction. Detailed family and social histories are sought, however, but cannot always be obtained at intake and are usually obtained by the psychiatric social worker assigned to the case over a period of days. These records are kept separate from the medical chart. Physical exams are done in detail and recorded with more than usual care. Special attention is always given to height, weight, and growth curves. All abnormal findings are recorded. Laboratory work is ordered on an individual basis. If the parent says the child bruises easily, the physician orders appropriate laboratory tests. A skeletal survey may be necessary to determine whether there are old or resolving fractures. This is frequently a key issue in terms of whether the child has been exposed to trauma before. Nursing notes are kept of parent-child interaction, parental visits and descriptive characterization of the child.

2. *Treatment of the child's injuries*. Once the child is admitted to the hospital, the medical and surgical problems are cared for in the usual manner. An orthopedic consultation is commonly needed. Opthamologists, neurologists, neuro-surgeons and plastic surgeons are occasionally consulted. (The malnourished child is placed on ad lib feedings of a regular diet.)

3. *Laboratory tests*. Many suspected child abuse cases receive a radiologic bone survey, especially if the child is under 6 years old. Sometimes the x-ray findings change a suspected case into a definite case of non-accidental trauma. If there are bruises, a history of "easy bruising," or subdural hematomas, the attending physician obtains a "bleeding disorder screen" (platelet count, bleeding time, partial thromboplastin time and prothrombin time). If there are visible physical findings, color photographs may be obtained before they fade for possible use in court in addition to x-rays.

In hospitals with specialized child abuse diagnostic and treatment units (such as the Children's Trauma Center associated with Children's Hospital Medical Center in Oakland, California), each day a unit aide checks the daily admission sheets, reads the charts and consults with attending doctors and nurses on possible cases of abuse. Among the warning signs: cases where medical findings appear inconsistent with the parents' explanation of what has taken place; a child who appears unduly withdrawn, frightened or combative; and, inappropriate parental expectations or perceptions of the child. If maltreatment appears likely, the caseworker meets with the family and the attending physician when possible to discuss the injury and to decide on whether to report it as abuse. (In California, reports are mandated to the police or the probation department.)* "High risk" families are defined as those in which all of the characteristics of abusive families are present, but in which there has not yet been any overt physical damage. "Failure to thrive," "emotional abuse," and accidents caused by neglect or failure to protect fall into this category.

4. *Elicit detailed facts concerning the injury*. As indicated above, a complete history is obtained, often by a physician on the ward, as to how the injury allegedly happened. (This includes place, the exact time, the sequence of events, people present, time lag before medical attention sought, etc.) The parents often are pressed for exact details if necessary. Hospitals try to obtain this history as soon after admission as possible, before the parents have had time to change their explanation.

5. *Helping the parent(s)*. Once the immediate medical crisis has been cared for, in some hospitals attention shifts from the child to intensive support for parents in the relationship with the social worker and perhaps the attending physician. Parents may be helped to get to the child welfare system as expediently as possible and to obtain legal counsel. In cases of admissions where the child does not return to the home, continued contacts may be kept with the parents offering them support until they can get to the appropriate agency and some disposition has been made regarding the child. If a child goes home or is retained in a foster home or shelter, continuing medical care, social casework or psychiatric evaluation may be offered to the families and the agencies. If the hospital disagrees with child welfare's assessment of the situation, the hospital itself can petition the court on behalf of the child or petition the court to obtain legal counsel for the child.

Hospitals usually do not see themselves as responsible for restoring families to emotional health, although some do. Where the family requires psycho-social follow up and treatment, this is viewed primarily as child welfare's responsibility. Ideally, the therapeutic program should begin while the child is still in the hospital. Some types of therapy that are reported to have been helpful in individual cases are lay therapists or mothering aides, homemakers, Parents Anonymous groups, telephone hotlines, day care centers, crisis nurseries, psychotherapy for the child, child-rearing group sessions, environmental crisis therapy, marital counseling, vocational rehabilitation, etc.

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*See Appendix III (III-5 and III-9)

6. *Specialized multi-disciplinary teams.* In many urban hospitals, medical, social service, administrative and legal staffs have formed official or semi-official child abuse teams to facilitate the diagnosis and treatment of cases brought to the hospital. A representative example of such a team approach is the SCAN (Suspected Child Abuse and Neglect) Program, a term first coined at the Mott Children's Hospital of the University of Michigan, has been operating at Children's Hospital of Pittsburgh for several years. This program has the following purposes and goals:

- to help identify children at risk and see that they get adequate protection and care;
- to assist medical house staff in dealing with the problems of abuse and neglect through a 24 hour a day consultation and to establish hospital guidelines for the management of these children;
- to provide continual in-service training programs and community consultation around the multiple problems of child abuse and neglect;
- to keep accurate records and constant check and double check on abuse cases;
- to arrange for families and children, referred from outside agencies such as Child Welfare and the courts to be seen immediately for medical intervention and/or psychiatric evaluation;
- to keep accurate follow-up on all cases either following these families with other agencies and by giving continual pediatric care;
- to hold weekly SCAN meetings with child welfare, medical house staff, school officials, members of the legal profession and other interested parties in an attempt to build up an informed body of people knowledgeable in the problems of the abused child and his family;
- to hopefully do much needed research when indicated and to develop and encourage more innovative community programs in the area of abuse.

The hospital-based team program, such as the SCAN program, is continually implemented by a committee which is made up of a number of professionals and non-professionals. For example, the Child Protection Team, which originated in the Department of Pediatrics at the University of Colorado under the direction of Dr. C. Henry Kempe in 1958, is the principal national model for multi-disciplinary, health-based prevention and treatment of child abuse. The Denver team has four pediatricians; three psychologists, all part-time, one child developmentalist; three social workers, one part-time; ten lay therapists; two research assistants; two coordinators; two clerks; one public health nurse; one psychiatrist; and one attorney. The team also consults with a radiologist, sometimes a neurologist, and an orthopedic resident.

A primary difference in hospital-based child abuse programs is the extent to which cases are reported to the police or court and the extent to which petitions are filed for court action. In order to contrast the two approaches, and the reasons for them, we will briefly describe the "Trauma X" procedures for child abuse case handling at Boston Children's Hospital with those of the Children's Trauma Center (CTC) at Children's Hospital Medical Center (CHMC), in Oakland.

7. *Trauma X approach.* Dr. Eli H. Newberger's article "The Myth of the Battered Child Syndrome" (15) cites studies by Holter and Friedman, Gregg and Elmer, and Sobel as demonstrating a common causal background behind *all* childhood accidents which has to do with the inability of a parent to nurture his/her children. In accordance with this 'more human view' of child abuse, Boston Children's Hospital defines its euphemism for abuse, Trauma X, as "a syndrome, with or without inflicted injury, in which a child's survival is threatened in his home." This diagnostic concept tries to measure the capacity of parents to protect their children, and may be dichotomized into two separate components: protection from the parents' own anger towards the child; and protection from hazards inherent in the child's environment. Parental inability to protect in these instances stems directly from ascertainable environmental conditions which may not be accessible through the traditional intervention modalities of many of the 'helping' professions.

As stated in the recommendations of the Committee on Child Abuse, convened by Massachusetts' Governor Francis W. Sargent (of which Dr. Newberger was chairman of the Subcommittee on Services), the "object is to define in a helpful way where intervention is to be directed; to identify the causes of the problem . . .; to focus less on the symptoms of the child than on what problems seemed to lead to those symptoms; to allow one to commit one's resources in such a way as to exert some positive impact on the family's ability to prevent them from happening again." The model introduced at Children's Hospital has the basic idea of "coming to grips with the complexity of each case and (to) tackle its specific important components directly . . . It may be, however, that effective lasting intervention is less a function of successful treatment relationships than a matter of defining and resolving specific problems of parents' lives. . .such as poor health, inadequate housing, no child care, and legal and monetary difficulties . . . It means, for us at the Children's Hospital, becoming advocates for these children and their families."(16)

For a physician to implement these principles of child abuse prevention and treatment requires both a legal framework for reporting and subsequent judicial intervention and a hospital-based diagnostic and treatment system with sufficient flexibility to allow for creative responses to the needs of individual families. (The necessary attributes for this model child abuse system are listed in a later Newberger article, "Child Abuse: Principles and Implications of Current Pediatric Practice.")(17)

The nature of the discussion with parents of a possibly abused child is determined by the member of the Trauma X team who handles the case. If a family presents in the emergency room with suspicious injuries, the on-call member of the Trauma X team or the physician on duty does not hide concerns about the child's safety, but the use of the word "abuse" may be avoided. There is discussion of the concern for the safety of the child and that the injuries may have been inflicted. Injuries which trigger involvement of the Trauma X team include injuries which are unexplained or those explained in a way which is incongruous with the observed condition of the child.

It is not a purpose of the interview to try to determine who inflicted the injury; that information is considered irrelevant to the immediate concerns of dealing with the child's safety and helping the family. Generally, Trauma X team members advise admission of the child, who is then examined more completely and treated medically. The social work staff also is on call for child abuse cases. There may be four or five hospital staff members involved in the initial conference with the parent of a child who may have been abused. The purpose of Trauma team conferencing is to examine options by which a child might be safely returned home. These options include involving the family in some support system within the community or temporary foster care with parental consent. If neither of these is feasible and there is imminent risk to the child, the hospital will petition to court (a Care and Protection petition).* The rationale here is that enforced intervention will be better for the family in the long run, and that the child will not necessarily be removed from the home. Permanent removal is the last resort and will never happen in the initial stages of court processing. Usually, families have been involved with the court system for at least a year, by continuance, and breakdown is so complete that there is little hope of reconstructing an environment safe for the child.

In complicated, serious or emergency cases, when court action may be indicated in the future, there may be a case conference. Attending are Trauma X team members, hospital staff on the floor in which the patient is staying, and community agencies with some involvement with the family. Permanent representatives on the consultation - case conference group include the Inflicted Injury Unit of the Department of Public Welfare (DPW), the Parent Child Center in Dorchester, and the Children's Protective Service.* These conferences tend to be large, involving up to 20 people. Options in the case are discussed. Normally someone involved with a case requests a conference - most frequently the social worker because she usually has the most contact with the family and is familiar with the family dynamics.

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*Massachusetts' reporting law states the following:

If a (physician, medical intern, medical examiner, nurse, or social worker) in his professional capacity has reasonable cause to believe that a child under the age of 16 years is suffering serious physical or emotional injury resulting from abuse inflicted upon him including sexual abuse, or from neglect, including malnutrition, or is determined to be physically dependent upon an addictive drug at birth, then (s)he is required to report the case to the Division of Family and Children's Services.

In addition, any person required to report under Section 51A who has reasonable cause to believe that a child has died as a result of any of the conditions listed above shall report said death to the Division of Family and Children's Services, to the District Attorney for the county in which said death occurred and to the Medical Examiners. . . .

*See Appendix III (III-2)

A report is filed if the case fits under the guidelines of the law. Determining whether a case is child abuse is viewed as a medical as well as a legal judgment. If the team is called into a case, it usually is reported. The team seldom gets "frivolous" referrals. Options considered by the teams include the following:

- *Examine the ways the child can be returned home safely.* This usually implies community agency contact, building community supports, getting relatives involved with the family or having a relative assume care and custody of the child.
- *Voluntary placement through the Department of Welfare.* If the parents can't take the child back, this option is considered. While budget cuts at Welfare have caused the department to scrutinize requests for placement more seriously, in an emergency situation and with a mutual recommendation from Children's Hospital and DPW caseworkers, usually the hospital can get cooperation.
- *Court action for temporary removal of the child.* The Hospital or Welfare may be the petitioner, based on which has more extensive knowledge of the case. This option is exercised in circumstances serious enough that there is serious risk to the child in returning home. For example, in the case of serious injuries, repeated injuries, denial by the family of the existence of a problem, or failure of the parents to come to terms with the helping agency (that is, Children's Hospital).
- *Permanent removal.* As indicated above, usually this occurs only after a case has been in court at least a year, with continuances, and usually with custody vested in DPW. If the parent demonstrates no capability to change and to come to terms with the need to change, the hospital may move for permanent removal of custody. For example, if the mother is addicted to drugs and cannot conquer her addiction, permanent removal of custody may be sought. This also occurs in cases of serious family breakdown where the family is not able to care for the child; or where there is demonstrated and persisting ambivalence toward the child. In the last case, the parent may not recognize the ambivalence - they may demonstrate it by not visiting the child, or repeatedly battering or neglecting it.

8. *Children's Trauma Center (CTC) Approach.** The determination of abuse, high risk, or neglect is made in consultation with the physician, CTC staff, and other primary professionals after the initial evaluative interview. If there is suspected child abuse, CTC staff informs the parents that they are obligated, under law, to report both to the police and probation departments. A crucial aspect of the interview with the parents is in clarifying the issue of confidentiality and in explaining the legally mandated reporting to police and probation. Another important aspect of the interview is informing the parents of the investigation procedures of the law enforcement authorities and what to expect during the investigation and the court procedures in which they will probably be enmeshed. Support for the family in dealing with this crisis and other crises they are experiencing is offered by CTC at this time.

Under California law, cases of abuse have to be reported within 36 hours to local police and probation. At the time of reporting, CTC completes a "report form", prepared by CTC staff, CHMC counsel, and the Oakland Police Department. This is then forwarded to both police and probation. It satisfies the requirement under law that reports be made both by telephone and in writing. In *all* cases involving abuse and where indicated in cases of neglect and high risk, a case conference is called by the CTC caseworker which includes all professionals involved with the family. This can include: the physician, CTC caseworker, probation investigator, police, public health nurse, private therapist, and any other appropriate person. The parents are included in this conference if at all possible. This conference is held during the period prior to the Juvenile Court Hearing which determines the placement of the child and focuses on the following concerns:

- Recommendations for the disposition of the child.
- Coordination of services to the family.
- Determination of primary and secondary therapeutic responsibility for the family.
- Information-sharing concerning the family.
- Determination of the roles each service and individual will have with the family.
- Preparation of those appearing in court as to the concerns of the court and court pro-

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*See Appendix III (III-9)

cedure (this is crucial for physicians who must testify about abuse).

- Development of a treatment plan.

Case conferences are held periodically to keep all involved agencies informed about the family, changes in court status, and therapeutic progress. The therapeutic process in the traditional sense does not begin until after the dispositional stage of court process.

The essential distinction between the two hospital-based diagnostic and treatment systems -- Trauma X and CTC -- is the question of control over the case in relation to the legal system. In Boston, the Trauma X team retains case control in terms of treatment decisions and court processing. While cases must be reported, there is no automatic police investigation or court action. In Oakland, once the CTC has reported a case, staff helps to prepare the family for the ordeal of police investigation and civil and/or criminal court actions. CTC staff members often present their views to the court and court decisions often are based on their recommendations. In other instances, judicial decisions are perceived by CTC staff as counterproductive in terms of case management philosophy and objectives.

NOTES

(1)*Draft Report of Phase I of the Family Development Study* (Boston, Massachusetts: Children's Hospital Medical Center, September, 1974).

(2)Cameron, see Section I.A., n. 6 *supra*.
In the absence of acute awareness of child abuse and abuse reporting, physicians, whose main interest is treating the injury, will not automatically consider abuse.

(3)Newberger and Hyde, see Section I.A., n. 62, *supra*.
"Additionally, the perceived effect of reporting is to bring to bear a quasi-legal mechanism which, while in theory nonpunitive in orientation, may be quite the opposite in practice."

Eli Newberger, Gerold Haas and Robert M. Mulford, "Child Abuse in Massachusetts: Incidence, Current Mechanism for Intervention, and Recommendation for Effective Control," *The Massachusetts Physician*, vol. 32, no. 1 (January, 1973). [AB#74]
"In Massachusetts, the small number of officially reported cases relative to the estimate of the actual number implies that physicians are reluctant to report cases to the Department of Public Welfare. This reluctance almost certainly has to do with the nature and quality of protective services in the Commonwealth."

Lawrence Finberg, "A Pediatrician's View of the Abused Child," (editorial) *Child Welfare* 45:1:28-33 (January, 1966). [AB#94]
The author, a professor of pediatrics, describes the frustration of doctors when confronted with the legalities and procedures that they set in motion by reporting. Frustration is particularly great when the child is removed from parental custody to a hospital, thereby tying up valuable space for solely custodial care and neglecting the emotional needs of the child. Doctors having become involved with a court system whose interests are often basically in conflict with their own, will be discouraged from reporting again.

(4)Silver *et al.*, see Section I.A., n. 56 *supra*.
Results based on a return of 179 questionnaires suggest that methods of communication between medical and community organizations and the physicians have not been completely effective in familiarizing the physician with the battered child syndrome or with the community procedures to be used for the reporting of child abuse cases.

Raffalli, see Section I.B., n. 64 *supra*.
Parents deny battery of their children. . . (and) doctors not trained to interrogate parents have difficulty in questioning them.

(5)"Why Most Physicians Don't Get Involved in Child Abuse Cases and What to do About It," Children Today, vol. 4, no. 3 (May-June, 1975). Adapted from a presentation at the 43rd annual meeting of the American Academy of Pediatrics, San Francisco, October 1974.

(6)Eli H. Newberger, M.D. *et al.*, "Reducing the Literal and Human Cost of Child Abuse: Impact of a new Hospital Management System," *Pediatrics* vol. 51, no. 5 (May, 1973). [AB#75]
"These include the personalities of. . . .parents, for whom denial and projection often serve as principle means of ego defense; (his) family's anxious confusion; . . .the exigencies of life in poverty, including mistrust of community agencies, racism, unemployment, and drugs; the clinical team's frustration generated by missed appointments, confrontations with angry parents, and time-consuming contacts with outside agencies; and conflicts among responsible personnel stemming from the emotions brought forth by prolonged contact with disturbed families."

(7)Kempe and Helfer, eds., *Helping the Battered Child*, "The Consortium," see Section I.A., n. 33 *supra*.
"By their very nature, the problems of child abuse encompass the responsibilities of many disciplines within a given community. Herein lies the basic difficulty confronting every community which tries to provide services for these children and their families."

(8)For example, the Children's Hospital euphemism for abuse, Trauma X, focuses on *risk* to the child, rather than on the intentions of a family, by defining it as "A syndrome, with or without injury, in which a child's survival is threatened in his home." In not relating directly to the severity of any injury, this concept recognizes danger to children whose injuries are not sufficient to warrant removal from the home.

(9)Eli H. Newberger, "A Physicians Perspective on the Inter-disciplinary Management of Child Abuse," *Child Abuse: Intervention and Treatment*, see Section I.B., n. 63 *supra*

(10)*Ibid.*
"The distinguished child psychologist Urie Bronfenbrenner has observed that American service institutions often serve to divide rather than to integrate families. . . we can often see

the destructive consequences of separated institutions which attend to various aspects of welfare, health, and child development, but which cannot — because of their organization — work effectively together to strengthen family life." The implication here is that the territorial aspect of social work described above relates more or less equally to all service delivering agencies.

Joan C. Holter and Sanford B. Friedman, "Child Abuse: Early Case-Finding in the Emergency Department," *Pediatrics*, vol. 42 no. 1 (July, 1968).

It is recommended in this article that a greater degree of utilization of ancillary medical personnel, such as pediatric and public health nurses and pediatric social workers, should be allowed and would permit more comprehensive medical care

(11)Harold D. Bryant *et al.*, "Physical Abuse of Children - An Agency Study," *Child Welfare* (March, 1963), pp. 125-130. [AB#44]

Dual agency responsibility is discussed here as the agency's obligation to provide on-going services in an attempt to keep the family together where possible and, at the same time, developing planned processes of case-finding in hospitals and other agencies to encourage reporting, which may result in the removal of children from their homes.

(12)Besharov, see Section I.A., n. 29 *supra*.

The author discusses the dual role of the child protective service worker – investigator versus helper – creating a stressful situation. "The combination of skills a child protective worker needs to be effective is staggering. He must be both a policeman and social worker, investigator and friend. Child protective services suffer because protective workers often cannot resolve these basic role conflicts."

"Even before the passage of the Federal Child Abuse Prevention and Treatment Act of 1973, which requires reporting of child neglect as well as abuse, the states were broadening the circumstances requiring a report. More than three fourths of the states now include child neglect in their reporting laws, and a handful specifically mention sexual abuse and emotional abuse or neglect."

(13)Kempe and Helfer, eds., *Helping the Battered Child*, "After Child Abuse Legislation - What?" see Section I.A., n. 31 *supra*.

Staffing standards must allow for personnel to continually adapt and modify their practices in terms of impact on their clients' lives. The authors here recommend a new role for professionals engaged in providing protective services — activism in mobilizing the public backing necessary for the achievement of adequate financial support.

Newberger, n. 9 *supra*.

Newberger here states that "too much work for everybody, and a sense of hopelessness and despair in the face of overwhelming problems and unsympathetic colleagues. . .probably accounts for the large yearly turnover of social work personnel in public agencies — with the resulting loss of continuing service to individual families and of precious, experienced manpower."

(14)Catherine E. Campbell, "The Neglected Child: His Family and His Family's Treatment Under Massachusetts Law and Practice and Their Rights Under the Due Process Clause," *Suffolk Law Review* 4 (1970), pp. 631, 634.

Even if public agencies recruit qualified personnel, the turnover rate for caseworkers in the area of protective services may exceed more than 50% in one year.

Kadushin, see Section I.B., n. 37 *supra*.

(15)Newberger, "Myth of the Battered Child," see Section I.A., n. 51 *supra*.

(16)Newberger, Haas and Mulford, n. 3 *supra*.

(17)Newberger and Hyde, see Section I.A., n. 51 *supra*.

CHAPTER V. THE LAW ENFORCEMENT ROLE IN HANDLING SUSPECTED CHILD ABUSE

A. Approach to Police Intervention

Police are "peace officers" with a 24-hour, 7-day peace-keeping role. Keeping the peace involves law enforcement and prevention of law violation. Determining whether law enforcement or law violation prevention is appropriate requires a "diagnosis" of the problem discovered—in this case, suspected child abuse. When a police officer discovers an injured child, he/she is performing a case-finding and initial screening function which is unique and cannot be duplicated in any community by protective service workers or any other agencies. As part of the normal police role, they are necessarily one of the primary "protective service" agencies in early detection of child injury and suspected abuse. The issue is not whether the police perform this role but how and under what circumstances.

Under all state statutes, the police have initial responsibility for the investigation of all complaints or situations that come to their attention involving the violation of state and local laws, preservation of the peace, prevention of crime, detection, and arrest of the perpetrators. The police have the authority in all states to take into protective custody any child who is seriously endangered in his surroundings and where removal is essential for his or her protection.

Typically a patrolman on duty would be sent out to a home to investigate a child abuse complaint. In some communities,* the police would contact the on-duty protective services worker to make the initial investigation unless the police report indicated an emergency or the complaint came to the police after hours. Where the patrolman investigates the complaint and there is evidence of physical injury, he or she would make a judgment as to the safety of the child and the necessity for removal of the child from the home to a hospital for a medical examination. In some communities, a social worker, say from a county child welfare agency, may accompany a law enforcement officer in initial child abuse investigations. If the child welfare agency follows up on a report, law enforcement may be contacted, depending on the circumstances, to aid in the investigation or removal.

Depending on whether child abuse is handled criminally or non-criminally, child abuse cases will be reported, investigated, and subsequently handled in fundamentally different ways. Legal designation of child abuse as criminal conduct inhibits reporting of child abuse cases; makes persons who become aware of child abuse incidents reluctant to report, especially in borderline or less than serious cases where discretion can be exercised not to report; and may result in reluctance of families under stress voluntarily to seek help or more prone to deny that injuries were intentionally inflicted. The more that police have a "law and order" image in the community, the more that police response to possible child abuse incidents is perceived, especially by helping professions, as having negative effects.

Even where specialized and extensively trained police juvenile or family crisis intervention units have been established, such as the unique Los Angeles County Child Abuse Unit,* the sensitivity for and generally non-punitive attitude toward handling child abuse cases may be offset by the public image of police generally and the inadequacies, especially in larger cities, of patrol officers who usually make the initial family contact in child abuse cases. At the same time, the police are the only 24-hour-a-day field service community agency and therefore are in the best position to discover child abuse, to exert legal authority to induce cooperation, and to handle cases with respect to constitutional rights and the process of law. Furthermore, based on our field interviews and observations, there is no doubt that, with proper staff selection, training, and supervision, police response can be extremely sensitive, nonpunitive, and flexible in suspected child abuse cases, greatly mitigating the generally detrimental effects of initial police involvement.

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*See Appendix III (III-5).

*See Apendix III (III-5).

In the remainder of this chapter, we will describe what should be guiding principles, practices, and roles of law enforcement agencies in the identification and investigation of suspected child abuse (and other maltreatment) cases, only a small fraction of which may lead to a decision to criminally prosecute. The model system assumes that police will continue to receive many complaints or reports of child injury or suspected child abuse; to use their discretion in responding to these calls, many of which occur as part of the police role in family crisis intervention; and to have to make law enforcement and also human service-type decisions at the scene of the incident relating to the nature and circumstances of the child's injuries.

Frequently, police officers responding to reports of suspected child abuse cannot determine whether the injuries were intentionally inflicted or the nature and extent of the child's injuries. The parent or caretaker's explanation of the cause of the injury may or may not sound convincing. The officers do not know whether the law has been violated or the risk to the child of remaining in the home. Under existing laws and practices or under the model system, police officers have to make decisions in answer to five questions:

- Does the child need to be removed for its protection or for immediate medical attention?
- Does the child need a medical examination to determine the nature of the injury or the need for further medical examination and treatment?
- Can this examination be performed in the home or must the child be brought to a hospital?
- If emergency treatment or a medical examination in the home or in a hospital is necessary, is the parent willing to cooperate?
- Is there reasonable cause to believe that a civil or criminal law has been violated?

Under the model system, where the police decide that a child does not need to be transported to the emergency room of a hospital, specifically a CIMC, the police would contact the ICEU and request that a nurse be sent immediately to where the child is located. Ideally this request to the ICEU should be made simultaneously with receipt of a report by the police. The public health nurse would then be present at the initial contact with the child and parent(s), to examine the child and to participate in the decision regarding the need for medical treatment and further examination. On the other hand, when the ICEU receives a report of child injury or suspected child abuse, depending on the circumstances of the report, they would have the option of contacting the police for participation in the initial contact with the family or perhaps to proceed to the scene of the incident prior to the ICEU worker.

At least as important as how police procedurally respond to reports of suspected child abuse is the manner in which police present themselves to the family involved. Most families perceive police intervention in their home situation as intrusion. Police intrusion provokes anger, fear, defensiveness, humiliation, and various forms of hostility. When family members are in crisis — under stress beyond their ability to cope — the negative reactions to police intrusion may be even stronger.

Police presence is usually threatening. Their intentions may not change this feeling, but their demeanor certainly can make a difference. Police have the power to arrest and police demeanor can highlight this power. The literature on police-community relations in minority neighborhoods amply document the dynamics of this problem.(1) Consequently, the model system recommends that, wherever possible, police responses to child abuse reports be conducted by police in specialized juvenile units who have received training in family crisis intervention and all aspects of intervention in possible child abuse situations. Moreover, to the extent possible within police training resources, patrolmen should also receive a similar type of training.

The existence of specialized child abuse or juvenile personnel in a police department also make a great deal of difference as to the frequency of criminal investigations and prosecutions under any state or local system: in all likelihood, there will be a greater percentage of cases that never reach the city attorney's or district attorney's offices for prosecution. Prosecutors usually only see cases that police refer to them.

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[1] Freud, Goldstein and Solvit, see Section I.B.n. 61 supra.

B. Guidelines for Police Intervention Procedures

1. *Purposes of the investigation.* The purposes are twofold:

- Protection of the child is the primary purpose.
- The collection of evidence for the purpose of possible criminal prosecution, or for the purpose of juvenile court action, is the secondary purpose.*

2. *Role of the police in investigation of abuse.* The literature on child abuse cites a number of reasons why police should have a role in the investigation of abuse:(2)

- The traditional police function is the protection of persons and property.
- The size of most police forces and their 24-hour availability make them the one agency most capable of providing immediate protection to children.
- Law enforcement agencies possess the legal authority for removal and arrest if necessary.
- Police training and experience in standard criminal investigation procedures — i.e., techniques of observation, familiarity with rules of evidence, testimonial competence, etc.

3. *Alternative methods for handling the investigation.*

a. *Abuse cases versus neglect cases.* The first determination made is whether the circumstances more readily fit neglect than abuse. In many cases of abuse it is easier to view the matter as one in which the injuries are the result of parental failure to offer proper care and supervision than it is to attempt to show the parent actually and willfully attacked the child. This is very true, for example, in situations where the child had been denied medical attention for an obviously serious injury for any considerable period of time. Establishing the parental failure to seek medical aid is fairly simple, whereas the attempt to prove inflicted trauma may be quite difficult.(3)

b. *Criteria for suspecting child abuse*(4)

- Injury which is inconsistent with the parent's explanation.
- Certain characteristic injuries:
  - cigarette burns
  - distended fingers and limbs
  - non-accidental bruising patterns
  - repeated injuries
  - injuries at different stages of healing
  - complications arising from old injuries that are not adequately explained by the parents
- Attitude or conduct of the parents towards the child or towards the situation.
- Unusual behavior of the child.

c. *Emergency and non-emergency cases*(5)

(1) *Emergency cases*

- Remove the child from the home if his/her safety is endangered.
- Ensure that the injured child receives immediate medical attention.
- Obtain photographs of the injuries — the most significant evidence, apart from the medical testimony, are photographs indicating the visual effect of the injuries to the victim. These are taken as soon as possible after the child has come to the attention of the medical services or the police. Photographs in both black and white and color are made of all bruises, marks, lesions, burns, or areas requiring medical treatment. The investigator remains at the scene when the photographs are being made and assists the photographer in pointing out the marks and bruises that need to be recorded.

  A majority of photographs are obtained while the child is at the hospital or the doctor's office. Therefore, the police have to use the procedures of that institution or doctor in the proper channeling of the request to obtain photographs.
- Photograph the "crime scene."
- Write a complete report of injuries including the physician's remarks.
- Collect the physical evidence, such as the instrument used to inflict injuries. In the collection and preservation of evidence, police frequently attempt to obtain evidence of any nature, admissable or not, because some pieces of inadmissable evidence, such as hearsay, can be utilized by social agencies in their subsequent efforts

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*In many cases, the police investigative process will fail to uncover either the full facts of how the incident took place or the identity of the responsible party, leading to the inability to prosecute. This means that the majority of police investigations are directed towards juvenile court action, not the adult court. The evidence to be sought is similar in either action so that, in the process of preparing a case for juvenile court presentation, the officer is also gathering evidence that can be used in adult criminal action if that should arise.

in a case after court adjudication. This means that the officers often involve themselves in gathering background family and social history.

- Collect other evidence for laboratory examination. For example, in cases where the victim has been scratched, fingernail scrapings are made of the suspect's fingernails. To obtain these, the suspect may be placed under arrest or the officer may obtain a search warrant. Few people will voluntarily submit to such procedures.
- Check the child's medical history for previous indications of injury or abuse.

(2) *Non-emergency cases*

- Observe the physical condition of the child.
- Consider the attitude of the parents towards the child.
- Consider the child's general environment, including living conditions, health, and "moral hazards."
- Interview all parties involved, including complainants, child, parents, neighbors, relatives, friends.

  Suspected parents/caretakers: Each parent is interviewed separately with special attention to intentional vagueness or inconsistency (i.e., account to physician versus to police) and to statements that reveal unrealistic or inappropriate expectations of the child.

  Child: The child is questioned if he/she is old enough. The police officer avoids asking leading questions. (The child may be afraid of his/her parents and, therefore, refuse to cooperate.)

  The person(s) suspected of inflicting an injury usually are not interrogated on first contact. Rather, the suspected party is allowed to describe the circumstances of the incident without interrogative pressure on the part of the investigator.
- Check records of parents for previous child abuse involvement.
- Check child's medical history for previous indications of abuse. This may require an inquiry to area hospitals and doctors as well as determination that old and/or repeated injuries are in different stages of healing.
- Evaluate evidence of the injury to determine if it may continue and endanger the safety of the child.
- Record the incident fully and forward the report to the appropriate social agency.

d. *Removal of the child.* A police officer has both the authority and responsibility to immediately take into custody any children who are found in a situation where they are liable to be subjected to violence or injury. Removal is considered the appropriate decision when an officer believes that an injury to a child was other than accidental (i.e., to prevent further injuries). If a child is removed, the responsible child services agency usually is notified as quickly as possible. Criteria for removal of the child are as follows:(6)

- *Age of victim:* The age of the victim usually is a primary consideration in the decision to remove it from the home. Infants or children under three years usually are not allowed to remain in the home if the child has sustained a severe injury. This includes excessive bruising, evidence that the child has been burned, struck about the head or has received an uncontrollable spanking or strapping. Older children with limited marks and no serious injuries usually are left in the home pending other immediate action, including a referral to another agency. This action generally includes warning the parent that the child has been advised to seek aid in the event of a subsequent attack.
- *Extent of injuries:* The extent of the injuries, also related to age of the victim, are used as indicators of the hazards involved in leaving the child in the home. Inflicted burns, for example, almost always result in removal and juvenile court action. In a small child, any injury inflicted to the head or abdominal region, by the fist or other weapon, is viewed as requiring immediate protection. With older children, the injury is viewed in light of its severity and the circumstances under which it was administered.
- *Hostile home environment:* Unreasonable disciplinary action, resulting in extreme bruising or indiscriminate striking of various parts of the child's body, indicates a danger to the child of remaining in that home during the period of pending action. Such severe discipline is viewed as an indicator of a hostile environment that represents a real hazard to the health and safety of the child.

e. *Criminal prosecution.* "When a criminal statute has been violated, as is nearly always the case in incidents of child abuse, the investigating police officer is responsible for filing a report of all the facts surrounding the offense with the appropriate public prosecutor. The prosecutor makes the final determination whether the perpetrator will be prosecuted. This is based on the substantiability of available evidence, the balance of interests of the child, offending parent and community at large, available alternative means of disposition, and limitations on prosecution resources.'(7)

If the case is to be criminally prosecuted, the law enforcement agency acquires full responsiblity for the case, the development of evidence, and establishment of required elements of proof through standard criminal investigation practices. If the case is not to be prosecuted, active police involvement usually terminates, except for providing assistance in juvenile family court proceedings.(8)

(1) *Decision to arrest parents/caretaker.*

- *Immediate arrest.* This decision is based on the severity of the violence or injury to the child (e.g., homicide, extreme forms of injuries, such as extensive burns, multiple bone fractures).
- *Subsequent arrest.* Appropriate social service agencies are contacted before any final decision is made concerning the arrest. Arrresting the suspected perpetrator does not have to be done immediately. Once the arrest is made, it is difficult to avoid prosecution.

(2) *Criteria for criminal prosecution.* The criteria for deciding in favor of a prosecution of the adult offender in a battered child situation are as follows:(9)

- *Medical evidence and testimony.* The availability of medical testimony supporting the allegation of inflicted trauma is essential to the successful prosecution of such cases. This entails a medical diagnosis of the existence of inflicted trauma.
- *Other supporting evidence Re: abuse or neglect.* The evidence of the inflicted trauma usually is supported by accompanying evidence of other maltreatment falling into the area of repeated inflicted injury or general neglect. In addition to physical evidence, photographs, etc., the evidence developed aims at establishing a pattern of behavior by which it may be demonstrated that the child has been subjected to an environment tending to place him/her in a hazardous situation. The type of evidence collected also aims to point to the need for control over the parent that can only be obtained through criminal court prosecution, court referral to family service agencies, psychological counseling, psychiatric evaluations, etc. or the need for family contact on a continuing basis by a supervising agency.
- *Witnesses.* The police officer attempts to locate witnesses whose testimony will support either the specific violent act or the existence of previous conditions indicating a pattern of hazardous experiences for the child.

C. Guidelines for Handling Child Deaths

1. *Reporting of deaths to, and post mortems by, medical examiner or coroner.* In any instance when a child has died as a result of physical abuse or other maltreatment or unexplained causes, including Sudden Infant Death Syndrome (SIDS), this fact should be reported by the local law enforcement agency, physician or hospital to the appropriate medical examiner or coroner. The medical examiner or coroner should report his findings to the law enforcement agency and the appropriate district attorney and, if reported by a hospital, to the hospital. Often reports are not made of suspicious fatalities among children.

One of the main reasons for the lack of post-mortem examinations of fatalities among young children is the prevelance of the SIDS, a fatal disease of unknown cause which remains unexplained even after a complete post mortem. Although SIDS and child abuse usually are not discussed together in the literature on child abuse or in model legislation, the incidence of SIDS is so great that the problem merits much more than perfunctory discussion in connection with child abuse, especially in relation to the role of law enforcement.

2. *Sudden infant death syndrome and other child deaths.* SIDS occurs in children from approximately 2 months to 2 years of age. However, most often it occurs in those between 2 weeks and 4 months. Annually, 8,000-10,000 thriving, well-cared for infants die as victims of the sudden infant death syndrome.(10) This is 3 in every 1,000

live births, almost one sixth of all infant mortalities in the United States. In a large metropolitan area, such as New York City, one baby dies every day.

SIDS has no regard for race or economics; it strikes babies in every level of our society. However, babies who are black, Indian, Mexican or poor white Americans and whose families live in urban ghettos will more frequently be SIDS victims than babies of the more privileged classes.

Since SIDS strikes without warning, while the victim is asleep and without a physician in attendance, infant victims are delegated to the medical examiner or coroner for investigation. In many areas of the U.S., autopsy is neither mandatory nor is it performed on SIDS victims. Deaths are often certified by the neighborhood funeral director or a coroner unskilled at pediatric pathology. Consequently, SIDS is too often dealt with as a criminal case or certified as suffocation (or other unsubstantiated theories) which carry a connotation of negligence by the family.

One of the most serious problems with SIDS is that the mother or father or other relatives caring for the child feel a deep sense of guilt or responsibility in having missed something or having "failed to do something." Virtually every family losing an infant to SIDS feels responsible for the death, due to ignorance of the disease on the part of health professionals and the lay public. Without immediate understanding, the problem of guilt and deep grief are long lasting and destructive to the family unit.(11)

In most jurisdictions, ambulance services and the police department simultaneously respond to this type of emergency. (This response is not unlike the response to a very serious case of child abuse.) If the infant is alive, the police officer should initiate resuscitation efforts. At the same time, he should note conditions in the room and in the house; the behavior, attitude and remarks of persons present; the position of the infant; medical action taken; signs of rigor mortis and post-mortem lividity (settling of the blood), which are usually present if the body has been dead for more than 3 hours.

The child's clothing should be left on the body for a medical examiner to inspect. When this is not possible, the officer gathers the clothing for the medical examiner. The victim should be removed as quickly as possible to a hospital.

The scene should be disturbed as little as possible pending an extensive investigation of the death scene. Transportation to the hospital should be arranged for the parents — with a neighbor or relative, the ambulance or with the officer.

As indicated above, most parents feel a sense of guilt upon discovering their dead baby. This attitude will take many shapes and forms in the initial questioning — possibly misinformation, usually unintentionally. With this thought in mind, a consoling posture by the initial police officer at the scene is very important as well as the investigating officer who will be responsible for the classification and completion of the death report.

After the child has been transported to the hospital, the officer should ensure that photographs of the death scene are taken. Items possibly connected to the cause of death or near the body should be photographed and collected for scientific analysis. Unusual or hazardous articles, such as medicines, should be gathered if near the death scene. The place of death will have to be carefully examined, including the following factors:

- Type and position of the bedding.
- Unusual contents such as plastic bags, paint chips from a plastered wall.
- Presence of a defective or broken crib, or an open area, or an increased space between the mattress and the side of the crib.
- If the baby was found elsewhere other than the crib, such as a bed, does the entire family sleep together in a single bed — possibility of over-laying must be excluded.
- Inquire if the baby's brother, sister, parents or recent visitors were ill in any way.
- The presence in or about the house of pets including birds should be noted.
- Recent spraying inside and outside—insecticides; location of such cans or bottles used for this purpose.
- Occupation of the parents should be noted, especially if either one works around any toxic material which could be brought home.
- If baby is found in the care of a baby sitter, his or her habits, actions, and degree of health should be documented.
- Evidence of injury or infection (rash). The officer should know if resuscitation had been performed by the local fire department ambulance or other emergency agency, or a member of the family since some facial markings may result from applica-

tion of equipment; or bruises to the baby's face may have been caused by mouth-to-mouth resuscitation. If any vomitus has been found it might have been caused by such resuscitation.

Interviewing the parents will be very difficult for both the parents and the officer. The officer will have to explain that some of the questions may seem to imply responsibility for the child's death, but that they are routine and have to be asked as part of the investigation. At the same time, the persons interviewed should be warned that the information is part of a legal investigation; that the information could be used in later legal action; and that they have a right not to answer the questions (i.e., *Miranda* warning). Questions that should be asked include the following:

- Recent symptoms of the baby; physicians, clinics or hospitals where the baby might have been examined.
- Take note of terms used by the parent which might include "fussy," "colicky," etc.
- General eating habits of the baby: time and the variety of the last meal.
- Any recent or old injuries, however insignificant they may have seemed.
- Have the parents ever disciplined the child by spanking? How severely?
- Did anyone drop the child or did he/she fall recently?

If during the questioning inconsistent accounts of the death are given or any signs of abuse are found, the *Miranda* warning must be given once again and the interview should stop unless the parents, now suspects in a criminal case of homicide, consent to more questions.

At the end of the interview, the police officer should inform the parents that medical records of the child will be needed by the medical examiner. If the parents do not have a physician, they should then be referred to the public health service for family counseling by public health nurses.

Autopsies should be performed whenever possible. (In some parts of the country, autopsies are being done in less than one-third of SIDS.) The officer should be present during the autopsy. When an autopsy cannot be performed, the officer should request the medical examiner to obtain post-mortem studies such as chest X-rays, lumbar puncture, and blood cultures. However, an autopsy must be performed whenever criminal charges are to be placed.

The investigating officer responsible for the death report should also ascertain from the autopsy doctor if the baby died from an infectious or contagious disease so the officer or other emergency service personnel or parent could be warned to seek medical advice. Further, if in the opinion of the autopsy surgeon it appears an hereditary or congenital disorder contributed to the death, this information could be passed on to the baby's parents for possible use in future family planning.

After gross examination of the body, the medical examiner should send to the parents a brief letter certifying the official cause of death. In only a few communities in the U.S. do we see a humane system of dealing with SIDS. In King Co., Washington (Seattle), every SIDS is autopsied at a teaching hospital, the family is immediately contacted by the attending pathologist, a visit is made to the family by a trained public health nurse and a subsequent visit, two weeks later, is again made. Then the local organization of parents who have lost children because of SIDS contacts the family by letter and offers assistance.

NOTES

(1) Alan R. Caffey, *Police Intervention Into Family Crisis: The Role of Law Enforcement in Family Problems.* (Santa Cruz, California: Davis Publishing Company, 1974).

"Crisis Intervention," *Training Key #209*, see Section I.B. n. 19 *supra*.

(2) C.J. Flammang, *Police and the Underprotected Child* (Springfield, Illinois: Charles C. Thomas, 1970).

(3) *Ibid.*, p. 150.

(4) "Child Abuse," *Training Key #207*, see Section I.B. n. 19 *supra*.

(5) *Ibid.*

Flammang, n. 2 *supra*.

(6) Flammang, n. 2 *supra*.

(7) Kempe and Helfer, eds. *Helping the Battered Child*, "Role of Police," see Section I.A. n. 31 *supra*.

(8) *Ibid.*

(9) Flammang, n. 2 *supra*.

(10) "Sudden Infant Death Syndrome," *Training Key #208*, see Section I.B. n. 19 *supra*.

(11) Abraham B. Bergman, *A Study in the Management of Sodden Infant Death Syndrome in the United States* (National Institute of Child Health and Human Development, 1972).

CHAPTER VI. THE CIVIL ADJUDICATION STRATEGY AND PROCESS

A. Strategy of the Civil Adjudication Process

The model system could legitimately be termed a due process-oriented or civil libertarian model. The risk in designing such a model, however, is that legalistic procedure can nullify, contradict, or drown the purpose. The purposes of the due process model discussed in the following paragraphs are protection of the child from substantial risk of harm, whenever possible; preserving, stabilizing, and fortifying the family unit; and, at the same time, protecting the rights of parent and child. The strategy of the civil adjudication component of the model system design is to specifically limit the types of cases that enter the legal system as "child abuse" to physical injury; and then focus a civil court process on the risk to the child, and ways of minimizing the risk, of remaining in the home.

This strategy can be characterized as favoring formal court processing of child abuse cases over the informal processing or diversion of such cases. The concept and procedural aspects of pre-adjudication diversion developed in the model system are an integral part of and implement the basic strategy of narrowing statutory jurisdiction over child abuse. The grounds for intrusive and coercive intervention into the family unit are limited. Once these grounds are found to exist, full due process rights attach. Informal handling of child abuse cases still remains an option; however, the case must move towards either a formal court adjudication or the family should be referred for truly voluntary services and the possibility of court action is entirely removed. In other words, this strategy seeks to ensure that any informal handling of child abuse is minimally coercive and non-contingent upon the acceptance of offered services or satisfactory performance in the service or treatment milieu. Where any coercive intervention is considered necessary to insure protection of the child, this can only be done *after* the filing of a petition, through an adjudication hearing followed by a dispositional hearing.

In the present system, the civil court process often, at least implicitly, operates as a legal "sword of Damocles" held over the heads of suspected abusing parents. Parents quickly learn that they may not be "dragged through the courts" if they "voluntarily" accept certain conditions which often include the "voluntary" and "temporary" surrender of custody of the child. The "trauma" and "stigma" of a formal court process is thus avoided, but possibly at substantial cost to the basic rights of the uninformed and uncounseled parents. The civil court process understandably is viewed by many helping professionals as a last (coercive) resort. However, in fact, under the present system it is the *only* resort, coercive or otherwise, which offers even rudimentary due process and procedural protections for the parent and the child.

The model system views a properly constituted civil court process as offering the most basic institutional protections available to suspected abused children and their families. The result of the model system's strategy might be a higher incidence of child abuse cases which go through the civil courts at least to the point of adjudication.

These purposes and goals of the model system establish the framework for the following set of strategies and objectives for system development:

- The reduction of coercive diversion options without due process by limiting the authority to make coercive orders only to the court and only after due process hearings. Diversion from court process bars any further court proceedings based on the same case.
- The reduction of the time-frame for completion of civil court proceedings from petition through disposition by handling every child abuse proceeding as an emergency.

- The reduction of the extent of intervention into the family unit during the civil process by limiting each intervention to only that degree necessary to determine whether it is appropriate and necessary to proceed to the next step of the process.
- The separation of the judicial determination of substantial risk to the child, by virtue of the cause and nature of the child's injury (accidental/non-accidental), from the judicial determination of the remedies appropriate to deal with the degree of risk to the child and to protect the child from further serious harm.
- The reduction of the accusatorial aspects of court proceedings through the use of a court process that more closely resembles ordinary civil litigation and by focusing on the risk of harm to the child rather than the fault of the parent.
- A separation of the court's role as trier of fact and selector of an appropriate disposition from the role of investigation of the case and available disposition alternatives.
- A recognition of the limitations not only of any legal process to resolve the underlying causes of abuse, but also of the predictive value of the knowledge on which judicial judgments are based.

B. Key Components of the Civil Adjudication Process

The decision-making process in the model system requires either the filing of a petition (within a specified limited time) or the abandonment of the civil court process (and thus any coercion) in handling a child abuse case.

Possible alternatives other than simply lengthening the time specified in the model system would involve an open-ended, decision-making process where the resolution of whether or not court action will be commenced can be postponed indefinitely in all cases or only in those cases where custody of the child remains with the parents. But this would make an eventual filing of a petition potentially influenced by the interim behavior of the parents. Another alternative involves allowing pre-petition diversion where resort to court process remains an ultimate possibility. This can be used as another means of postponing the decision, which eventually must be made concerning the appropriateness of filing a petition. This also permits the imposition of services, not truly voluntarily accepted, without any determination by an impartial party of the necessity for and appropriateness of the services imposed and without any due process rights for the party coerced into accepting such services.

The interim custody of the child pending adjudication or pending the decision to petition is reviewed at frequently scheduled hearings with all parties present and represented by counsel.

Alternatives to this approach usually call for the custody of the child, which has not been "voluntarily" surrendered, to be reviewed at an initial hearing at the conclusion of which a placement is made that continues for the duration of the pre-petition and adjudication process, which can (and often does) extend for long periods of time. The model system establishes a minimum of at least one and a maximum of four custody review hearings, depending on the length of the pre-petition investigation process. Coupled with the shortened time-table for completion of the civil process, this minimizes the time a child can be held in temporary custody and insures that adequate continued justification exists for separating the child from its parents.

The concept that an injured child case is a "legal" emergency as much as a medical emergency is incorporated into the system and governs the time-frame for the decision-making and adjudication process. Child abuse proceedings take precedence over all other matters on the court's calendar until disposition, the county/city attorney's agenda, and the case-load of counsel for the parent and child.

Alternatives, both present and proposed, take into account the emergency nature of child abuse and child custody proceedings. However, on the crowded docket of an urban court, this might be translated into a 6- to 9-month process or longer. There is also implicit the assumption that more time will produce more information with which to make a better judgment. Such practices, however, do not take into account either the, child's sense of time or the severity of the interruption of the family's life. Six months is a relatively short time by present standards for completion of litigation. It is too long for a parent or child to wait to find out what their respective status to each other will be. The time-frame of the model system operates to advance decision-making in two ways. First, when the child is not in the custody of its parents, the continued temporary removal of custody is contingent upon filing the petition within 7 days of the child's referral to the CIMC. If the petition is not filed within that time, the child is automatically returned to its parents, and the court process is foreclosed. Second, if the petition is filed, limitations are placed on continuances of the adjudication and disposition phases thereby discouraging the present practice of repeated adjournments.

Alternatives could incorporate greater time periods *between* decision-making points; but the concept of some definitive limits on each phase of the process is essential to preventing long interruptions of the parent's custody of the child without a final resolution of the merits of the case.

Certain practices of ordinary civil litigation are incorporated into the model system adjudication process. The civil litigation model is used to define the relationship of the parties to each other and to the court and to define the role of the court in the process. Civil pre-trial practices including pre-trial conferences, and application of civil rules of discovery to the investigation process are also adopted.

More closely approximating the civil litigation model than present juvenile court practices promotes the movement away from an accusatory process in child abuse cases. Incorporating the civil model of a "non-aligned" court which oversees the pre-trial discovery process but does not directly supervise or conduct (through a court-based probation agency) the investigation also contributes to a less accusatory process and places the opposing parties on a more equal footing before the court. Limiting court access to pre-trial information only through the pre-trial conferences and only after full exchange of information between the parties also promotes a "non aligned" court.

Alternative approaches more or less follow the present juvenile court process model which operates in a quasi-criminal, quasi-civil manner. The investigation is conducted either by court-based staff (probation) or by protective services or other public agency. The court may select the investigative agency and may determine the scope of the investigation. A report of the investigation is forwarded to the court. The parties may or may not have access to this report prior to the adjudication hearing. The question of whether civil or criminal rules of discovery apply to juvenile court proceedings may not be adequately resolved. Where the court selects an agency to investigate or where a court-based agency performs the investigation, adequate controls on the investigation may exist. Comparable investigative and expert resources for the attorneys for the parent and/or child may be provided. Pre-trial conferences may be held to facilitate simplification of the issues.

The presence or absence of these measures, on balance, is what determines the "civilness" of the proceedings and the accusatory/non-accusatory nature of the process. The model system attempts to strike the balance in favor of a more purely civil, non-accusatory process.

C. Civil Adjudication Process

1. *Referral to county/city attorney.* The referral of a case from the CIMC to the county/city attorney marks the commencement of the civil adjudication process. This referral represents either that the medical aspects of the accidental/non-accidental issue have been resolved, as best they can be at the hospital, and that the injury appears to be non-accidental; or that a specified maximum period of time, e.g., 96 hours, from the time of a child's referral to the CIMC is about to expire and that the medical diagnostic process cannot be completed within that period.

The diagnosis concluding that the injury appears to be non-accidental may be based solely on a medical basis, i.e., the nature of the injury is such that it could only have been inflicted; or it may be based on a combination of medical findings and other factors. Such factors may include an explanation by the parents at intake that clearly does not correspond with the nature of the injury; previous unexplained old injuries; a record of a previous adjudication for child abuse in the family found in the CAIF; or these factors may include a history of foster placements of the child by voluntary agreements, or other factors which convincingly support a conclusion by CIMC staff that there is substantial risk that the child may be endangered in its present home environment.

Whenever a referral is to be made to the county/city attorney, the parents or caretakers should be informed of this fact by the hospital, the reason for the referral should be simply stated, and an explanation of the possible subsequent proceedings should be given.

2. *Pre-petition investigation.* The decision to be made by the county/city attorney upon a referral involves a determination of whether the hospital report provides a sufficient basis to support the filing of a petition. Not every case is expected to

be conclusively resolved by the CIMC diagnostic process. Moreover, certain cases, because of the complexity of the injuries or of the testing and evaluation process, cannot be resolved within the initial 4-day (96-hour) time frame.

At the point where a pre-petition investigation is called for, there is only a *suspicion* of child abuse. (Where there is probable cause to believe an injury is the result of abuse, there is no need for any further pre-petition investigation.) Thus, in keeping with the reasons discussed previously (II. B. *supra*) the police should not be involved in this investigation process. Nor should protective services, welfare agencies, or other agencies which may be relied upon to provide services to adjudicated families be involved.

The perceived conflict between an agency acting as both an investigator (accuser) and subsequent helper, as discussed previously, may seriously affect the development of a therapeutic relationship at the dispositional phase. Court-based probation also is not the proper party to conduct this investigation. A key objective of the model system's civil court process is to develop a proceeding that is more truly analogous to civil litigation where the contesting parties stand equally before an uninvolved tribunal. The use of court-based staff in the decision-making function of one of the parties, i.e., the petitioner, whether it involves the decision to file a petition, the development of facts to prove the petition, or the determination of the relief to be sought, undermines such a strategy.

The limits on the scope of a pre-petition investigation are designed to control the potential for overzealous intrusion into the family. This is in keeping with the strategy to limit the scope of each intervention only to that which is necessary to make the decision to go on to the next step of the civil adjudication process. At the point of the pre-petition investigation there exists only a suspicion of abuse. Thus, only the information necessary to resolve that suspicion is essential at that point in the process.

Lastly, the pre-petition investigation should not be open-ended with respect to time for completion. A key principle of the model system is that injured child cases are emergency situations and should be dealt with as such from the point of initial contact through court disposition. Long delayed decision-making phases are to be avoided. Thus it is suggested that any pre-petition investigation be completed within 3 days of referral to the county/city attorney or by the time the medical diagnostic process is completed, whichever occurs last. Except in unusual cases, such a time-frame should be sufficient to conclude whether there is probable cause to support the filing of a petition.

The overall time-frame envisions a maximum of 7 days, from the time of referral of a child to the CIMC, to resolve the medical aspects of the child's injury, conduct a pre-petition investigation where necessary, determine whether to file or not file a petition, and in the case of the former, to resolve the issue of custody of the child pending the adjudication hearing. This time-frame is intended to minimize the period of disruption of the family unit and to promote a speedy resolution of the interim status of the case, by reducing the presently over-long periods of time a family is kept in legal "limbo," without knowing whether the matter is going to court or not. This proposed procedure implicitly recognizes the "limitations not only of the legal process but also of the predictive value of the knowledge on which its judgment is based."(1)

In cases where a pre-petition investigation is called for, contrary to present practice, such an investigation should not be conducted by the probation staff, by police, or by any agency that could conceivably play a role in an eventual disposition service plan; nor should the investigation involve a social or psychological evaluation of the family. Instead, the investigation should be performed by the county/city attorney's staff or by an agency not involved in providing services to adjudicated families. It should be limited in scope to *additional* fact-gathering, i.e., the development of sufficient information to support a finding of probable cause that the injury was non-accidental or to support a conclusion that the injury was accidental. When such an investigation is commenced the court should be notified as well as the parents who should be afforded the opportunity to obtain counsel; and counsel for the child and a guardian ad litem should be appointed by the court.

The purposes to be served by the pre-petition investigation are either to develop additional information to determine the probable cause of the injury, or in the case where the medical evaluation is not completed (at the end of the initial 96-hour period) to prevent any further delay in the decision-making process beyond that required to complete the medical diagnosis.

In situations where the diagnostic process is not completed, the pre-petition investigation may serve either as a collateral source of information to be considered in the diagnostic process, or as the basis for determining the position to be taken with respect to the child's custody pending completion of the medical diagnosis, or as an additional basis for determining whether a petition would be legally sufficient once the medical diagnosis is completed.

3. *Filing of the petition.* The ultimate decision to file or not to file a petition will be made by the county/city attorney. The county/city attorney may conclude that there is insufficient evidence or that, for other reasons, even where there is sufficient evidence, the ohild's interests indicate that court action is inappropriate. As underscored elsewhere, specific harms to the child, and not parental fault concepts, should be the determining factor. Such a determination should be made in consultation with the CIMC's diagnostic team.

Whenever court intervention for child abuse is deemed inappropriate, the county/city attorney may refer the family to protective services or other appropriate agency if the child's situation involves substantial risk of imminent harm based on evidence of damaging neglect, failure to thrive or the like. Here again, this decision should be made in consultation with the CIMC's team of specialists. Under any circumstances, in lieu of court processing, the family may be referred to available community resources for voluntary services. Such referral, however, is non-coercive and unconditional. The decision to forego court processing is not contingent upon the parents seeking or not seeking the suggested services, and the county/city attorney's involvement in the case ends at the point of referral.

Petitioner discretion is incorporated in present court processing systems. The difference in the model system approach is to eliminate the coerciveness of such "diversion" decisions by making them non-contingent or final. The emphasis is placed on a decision based on a realistic appraisal of the expected harm to the child that is to be prevented and why the decision either to petition or not petition is best suited to protecting the child from that harm while not causing or promoting additional harms.

Focusing this discretion at one point in the process—the point of petitioning—and by limiting this discretion to one individual — the county/city attorney—increases the potential for monitoring the decision and minimizes the possibility of abuses of discretion. The need for earlier diversion points is not as pressing, since the model system concerns itself only with already injured children and the usually protracted time-frame from an initial report of suspected abuse to the petition filing stage is greatly reduced.

4. *Interim custody of the child.* The interim custody hearing serves either as a continuation of the periodic court review of the child's emergency custody status begun with the TPRO procedures (see Part 2, Chapter IV, C), when a petition is not filed after the 96-hour period, or as the forum to resolve the child's custody pending the longer adjudication period, when a petition has been filed. In either case it marks the point in the process where, if abuse is suspected, the custody of the child cannot be determined solely by obtaining further parental consents. If custody is not to be returned to the parents or if the child is now sought to be removed from parental custody, it is to be done only after the parents have consulted with counsel, the child has had counsel and a guardian ad litem appointed, and the court has reviewed the merits of the custody issue. The parties may enter a consent agreement rather than contest custody; however, this is done in a formal court process and is subject to court approval.

When a child has suffered injury or trauma and abuse is suspected, there are many pressures which focus both on the parent and child. Professionals (physicians, protective service workers, hospital personnel, probation workers) often shocked at the nature or severity of the injury, may react strongly by insisting that the child not be returned home. Parents, often fearful of adverse consequences, may consent to the professional's position in the hope of avoiding further involvement in the civil or criminal process. Under such circumstances, informed, voluntary, well-reasoned consents are highly unlikely. By moving this consent process into the forum of the court after an initial period of time, and by insuring that the interests of all the parties are represented and considered, the interim custody decision should reflect a more accurate assessment of the needs of, and risks to, the child. Removal or continued removal of custody of the child from the parents will occur only if all other means short of such intervention are inadequate for the child's protection.

Thus, at the time of the filing of a petition or at the conclusion of the initial 96-hour period, the interim custody of the child is determined through a court hearing with all parties present and represented by counsel, whenever the child is not to be returned to the custody of its parents. The court may direct that the temporary or interim custody of the child be with an agency or person other than the parent only if there is probable cause to believe that the child would be at substantial risk in its present home environment. An explanation of the alternatives, not involving the removal of the child, which were considered during the hearing process and why these alternatives were not sufficiently adequate for the child's protection should also be included in the text of the order (for details of the custody hearing process see: "Model System Chart II, Phase III Civil Adjudication Process").

5. *Adjudication phase*. The adjudication process establishes that the child is at risk on the basis of the evidence of non-accidental injury. However, the nature and degree of the risk, which cannot be judged by the type and severity of the injury, or even by its willful infliction, remains to be determined in the disposition phase of court process. (In the disposition plan, the court will seek to define, through appropriate studies and additional diagnostic processes, the types of services and treatment that may be sufficient to reduce the risk to the child by stabilizing and supporting the home environment or selecting an alternative home environment.)

The model system proposes an adjudication phase, i.e., pre-trial proceedings and trial, that would as closely as possible resemble a civil litigation process in its essential aspects while incorporating a shortened time-frame for completion of the adjudication phase, in keeping with the emergency nature of child abuse proceedings.

The pre-adjudication investigation more closely approaches civil pre-trial discovery procedures than investigation procedures in juvenile cases (including neglect and child abuse cases) as they presently are handled. Following the same format as the pre-petition investigation, the pre-adjudication investigation would be conducted by the petitioner's (i.e., county/city attorney's) staff rather than by court-based probation, by police, or by protective services or other agencies involved in providing services.

The scope of the investigation, again consistent with the model system strategy, is limited to the discovery of only that information necessary to proving the allegations of the petition. A separate pre-disposition investigation is called for to gather information necessary for formulating a disposition. The information needs for disposition are much broader than for adjudication. Adhering to a least intrusive intervention policy, the mere filing of a petition should not offer a carte blanche opportunity to probe into the family's social history and life-style. The permissable scope of the investigation should include access to the medical records of the child and any siblings; prior court records, *only* if the family is listed in the CAIF; collection and examination of physical evidence; and locating and questioning of witnesses and experts.

Access to this level of information is reasonable. Physical evidence and eye-witnesses or experts, when these are available, are essential elements of proving a case and involve little if any intrusion into the privacy of the family. Such hard evidence, however, is rarely available in child abuse cases. Thus, access to medical records and the CAIF becomes necessary to the development of circumstantial evidence, while still not amounting to a personal intrusion on the family. However, when a home environment evaluation, or psychiatric or psychological testing and evaluation of the child or parents is desired, it should be contingent upon consent or pursuant to a form of "order of discovery" issued by the court following a hearing.

The implementation of this investigative process could be accomplished by application of existing civil rules of discovery. A preliminary pre-trial conference could be held shortly after filing of the petition among counsel for the parties and the judge in chambers which would map out the scope and time-frame for completion of the investigation and which would provide an opportunity for any objection to be made. Counsel for the parents and child would be equally entitiled to discovery of any medical reports, records, and the like obtained by the county/city attorney. Each would be equally entitled to a request for psychological or psychiatric testing or evaluation of the other party by consent or court order. The results of such tests or evaluations would be discoverable by all other parties.

The preliminary pre-trial conference would also set a date for a final pre-trial conference at which time the issues still in dispute would be determined, lists of witness and statements of the nature of their expected testimony would be exchanged, and the overall course of the trial would be developed in a manner similar to what is presently being done in other civil pre-trial conferences.

The purpose of such an arrangement, as is the case in other civil matters, is to reduce the element of surprise in such proceedings and to provide the fullest opportunity to discover the other party's case, thereby promoting a sensible and realistic appraisal of the merits of the litigation and maximizing the opportunity to arrive at a settlement (or consent agreement or plea bargain) in lieu of a trial.

Throughout the entire pre-adjudication process, the court's role is limited to presiding over the discovery process and arbitrating disputes concerning discoverable information. Neither the court nor a court-based agency assists or directs the actual investigation. Contrary to present practice, investigation reports are not prepared for or presented to the court. The court is informed of each party's case at the final pre-trial conferences only after the parties have completed their respective discovery process and have exchanged information.

Whenever possible, the adjudication hearing should be held within 10 days of the date the petition is filed. Where additional time is required, a continuance for good cause or upon consent of the parties may be granted. The hearing itself will be conducted in the same manner as under the present system. At the conclusion of the hearing, or at any time prior, if the petition is without merit, it shall be dismissed by motion of any of the parties upon the court's motion.

Where the parents admit the allegations of the petition or where they are proven by preponderance of the evidence, the court will enter an affirmative finding and schedule a disposition hearing.

Unlike present practice, an "adjournment in contemplation of dismissal" is not a possible order of adjudication. A settlement (consent agreement or plea bargain) will require either immediate dismissal of the petition or affirmation of the petition with the possibility of expungement at the conclusion of the period of the disposition order. (See "Disposition Phase").

6. *Disposition phase.* Dividing the civil court process into two stages—adjudication and disposition—permits the separate and independent consideration of remedies available and appropriate to protect the child from the risk of further harm or injury. Since the type of information needed to develop a disposition plan can be significantly different from that required at adjudication to prove the allegations of the petition, a bifurcated civil process prevents the overlap of disposition information into the adjudication process.

The model system calls for a wide range of dispositional services and alternatives to be available to the parties and the court. In the present system, the court is often faced with little choice between removal of the child from the home and leaving the child in the home with few services for the child and even fewer for the parents. Moreover, even when the child is removed from the home, little may be done for the home environment to ensure that the risk of further harm to the child is minimized. The end result is that the child is left in a temporary custody "limbo."

Courts are reluctant to consider permanent termination of custody proceedings, since the lack of assistance to the parents is not the result of their own doing. They are equally reluctant to return custody of the child to the parents since the lack of assistance leaves the home situation unchanged. The result frequently is long-term foster care placements and the shuffling of children from foster placement to foster placement. Without a sharp increase in both the types and extent of services for children and especially families, any other improvements in handling child abuse cases are unlikely to provide lasting benefits. Moreover, any strategy which calls for the selection of the least intrusive alternative at disposition and which seeks to minimize the necessity for removal of the child from the home for protection is contingent on the availability of and access to such services as individual and family counseling and therapy, medical treatment, homemaker services, day-care and child-care services, and the like.

Under the model system, temporarily removing the child from the home can occur only if it is established that there is no means to adequately protect the child from further harm without removing it from the home and only after a finding that the placement available is likely to be less damaging to the child than its own home. The purpose of the disposition phase of the model system is to guide the court in making this decision and in selecting appropriate services for the child and family.

Upon adjudication, the court would direct the local child protective services agency, probation or, preferably, a specialized unit of probation to conduct a dispositional study. The dispositional study would be two-fold: an evaluation of the nature and extent of risks to the child, and an evaluation of specific programs and/or placements for both the parents and the child which will be needed in order to prevent further harm to the child from the identified risks. The evaluation of the nature and extent of further risks to the child may include an evaluation of the physical facilities of the home, the adequacy of the parents' income in meeting the needs of the child, the identification of persons who would have access to the child (to be obtained from the parent only) and, if not previously performed, psychiatric or psychological testing and evaluation of the parent(s).

At the conclusion of such a dispositional study and prior to the disposition hearing, a dispositional report would be submitted to counsel for the parent(s) and child. Counsel for the parent(s) and child may also prepare reports based on their findings and adequate support staff should be available to counsel to explore dispositional alternatives. Contrary to present practices, predisposition reports will not be submitted to the court until all parties have had the opportunity to prepare their own recommendations contained in any other party's report.

The disposition hearing should be held within a specified time, (e.g., no later than 10 days) following either adjudication or the entry of a plea admitting the allegations of the petition. Where the dispositions of the case are in dispute, the purpose of the hearing will be to aduce evidence to resolve the issues in dispute and to formulate a disposition plan. Where the parties agree to a disposition, the purpose of the hearing will be to determine the propriety and duration of the disposition plan.

The disposition ordered by the court (or agreed to by the parties) should expire after a specified and limited period of time (e.g., 6 months) unless one of the parties requests, and after another hearing the court approves, an extension of the plan for a similar additional period.

Upon satisfactory termination of the dispositional phase, the court may, on its own motion or at the request of any of the parties after a further hearing, direct that the record of adjudication in the CAIF be expunged.

CHAPTER VII. ACCOUNTABILITY AND PERFORMANCE MONITORING

The basic framework of model system accountability would be the operating, planning, and monitoring requirements of the social service amendments to the Social Security Act, referred to as Title XX (P.L. 93-647), which went into effect October 1, 1975. Title XX, signed into law on January 4, 1975, provides for a decentralized program of Federally supported services set forth in an annually updated Comprehensive Annual Services Program (CASP) Plan. The CASP, prepared and administered by the designated Title XX agency, encourages active participation by private organizations, agencies, and individual citizens in its development and implementation.(1)

The process of planning and reporting is goal-oriented, for case planning and statewide planning, and public accountability oriented: how did the services provided and the results achieved compare with the CASP and its projected costs? The plans for services to target groups, such as abused and maltreated children, must be developed in a public process. Results of the Title XX service program must be publicly reported along with evaluations. The program is supposed to be designed to meet the specific needs of decentralized geographic areas and the individual needs of clients, the aggregate result of which is the state's plan and program report for public accountability purposes.

Throughout this Prescriptive Package, we've stressed that gaps in baseline data, causation studies, and service program impact assessments need to be filled pertaining to every aspect of handling child abuse. Relevant data and research in the field of child abuse, as in other human service areas, will be very difficult to obtain, especially in the short term. While longer-term research programs are being developed under the Child Abuse Prevention and Treatment Act, there is a need for applied research, or what we term detailed program assessment, focused on pressing information needs.

What differentiates detailed program assessment from research evaluation are their respective purposes and methodologies. Research evaluation is designed to assess impact or effectiveness. Detailed program assessment (sometimes called "process evaluation") answers the question of whether or not a program or project was implemented in accordance with its goals, methods, and guidelines. Implementation of the model system, on a pilot basis in one or more communities, or on a broader scale, requires detailed program assessment that focuses on the processes of innovation diffusion. More important than the findings of formal research per se in promoting change in child abuse handling systems will be the backgrounds and frames of reference of particular innovators in pilot communities which decide to undertake implementation of the model system.

Lack of formal research findings in child abuse certainly is no deterrant to development of existing systems. Existing research that seems to answer the needs of practitioners in the child abuse field does so because it fits pre-existent frames of reference developed in various professional fields (e.g., social work, medicine, mental health). Most practitioners don't have the time to invest in translating what is known and unknown based on research findings into their practical work situations. Probably much of the research would not answer their day-to-day needs in any case. Consequently, the Prescriptive Package is designed to facilitate, to begin with, a crude accountability and performance monitoring process which asks the following kinds of questions:

- How many suspected child abuse cases were identified in the community this year as compared to last year, by what sources?
- What happened to these cases of suspected abuse? How many cases actually had injuries that would qualify as abuse?
- In how many of these cases was legal action initiated? With what outcome in the court process?
- What type of emergency services were provided after case identification?

- What type of services were provided in connection with medical diagnosis, pre-adjudication, and post-disposition? How were these services funded? What are the service and funding gaps?
- What are the principal barriers to achieving the objectives of the model system? How can these operational barriers be minimized or removed?

All of these relatively unsophisticated, process-type questions have to be answered in connection with Title XX reporting and monitoring requirements. It will be noted that none of the questions address whether the parents or caretakers of abused children ceased to be abusive or whether the children recovered to function normally or whether parents and children were enabled to improve the quality of their lives. Rather the questions all ask: what is the system, its components and activities doing in relation to objectives for case handling specified in a CASP Plan.

The implementation of the model system in any state or discrete geographic area requires a *needs assessment* which also is necessary for developing a CASP Plan under Title XX regulations. The needs assessment should focus on needs by target group and the reallocation of scarce financial resources directed at helping the most vulnerable children and youth.

In the model system, we are proposing to limit the definition of the target group diagnosed as abused and assigning a high priority to these children in the process of shifting the limited resources available for children's services. However, we recognize that children also die of and are severely injured by neglect. *Hence, the criteria for limitation of or priorities for target group services under a balanced Title XX package should focus on those children who are in the most danger, whether from abuse or neglect.* This may include several children within the same family, one of whom is physically abused and others who are severely neglected, all of whom would qualify as "primary recipients" under Title XX.

The model system proposes development and implementation in local communities of a variant on the comprehensive emergency services (CES) program pilot tested by the Nashville Urban Observatory's National Center for Comprehensive Emergency Services to Children.* The basic purpose of the model system's CES program would be to identify and meet the crisis needs of children who are in the most danger, and of their families, with priority for injured children. A second basic purpose of the model CES system is to prevent the inappropriate removal of the child from his/her home whenever possible. All of the emergency care options for providing protection and reducing the trauma of the family crisis available under the Nashville CES would also be available under our model CES program. The basic differences would be the model CES system's use of public health nurses as the primary intervention agency and the sequence of medical diagnostic steps following identification of suspected abuse.

It is assumed that most of the services provided under the model system would qualify either as protective services under Title XX, including the hotline and media campaign (i.e., expanded information and referral services) and medical services which cannot be paid for under Medicaid. Medicaid, Blue Cross, and other medical payment systems would cover medical diagnosis and treatment costs by hospitals for individual battered children. The CIMCs could arrange contractual purchase of service arrangements with the state's Title XX agency to cover diagnostic costs of the multi-disciplinary team effort over and above Medicaid reimbursement.

Under the model system, the CIMC would be a particular focal point for performance accountability monitoring. Requirements for CIMC performance accountability would have to be incorporated in its licensing and contractual agreements with the state and also with local entities in the child abuse handling system. Under the model system, we envision development of a primary set of contract agreements between the ICEU, the CIMC, and public and private protective services agencies, and the designated Title XX agency defining the scope and type of functions, services, and procedures performed under the model system. A secondary set of contract agreements could be developed between the CIMC and civil counsel for the local jurisdiction with respect to diagnostic and reporting responsibilities of the CIMC for cases diagnosed as suspected abuse which are to be referred for review pursuant to the decision to file a petition.

Under the terms of such contracts, the ICEU would provide the designated Title XX agency with statistical data on all cases examined, cases referred to the CIMC, and cases offered emergency services. In referring these cases to the CIMC, the ICEU would assign a unique numerical identifier to the case which could also be used for subsequent reporting purposes to the Title XX agency by the CIMC and protective services to identify cases handled by any of these agencies under the Title XX plan. The other common statistical information would include: age of child; sex of child; family status (i.e., natural parent, guardian, other caretaker); type of injury (CIMC only); number of other siblings in the home; disposition of case; services provided (as defined in the CASP); method of service provision (i.e., direct; purchase of service from specified agency); and Title XX, Title IV or Medicaid eligibility. In this manner, Title XX service reporting requirements can be met, by tracking numerical identifiers from various sources, thereby dealing with performance monitoring of services, without resort to a central register, by utilizing the existing Title XX information systems.

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*See Appendix III and Appendix IV.

Under a contract with the office of the locality's civil attorney, the CIMC could provide training and consultation to the attorney's:

- Suspected child abuse cases identified in hospitals and examined suspected child abuse cases referred for petitions.
- Number of petitions filed.
- Number of children referred for petitions kept at home until and after court hearings.
- Types of temporary placements used until court hearings and post-disposition.
- Number of dispositions involving termination of parental rights.
- Number of adoptions resulting from termination proceedings.
- Number of times children moved from one placement to another.
- Number of abuse cases appearing in petitions more than once, in the same home and in placements.
- Primary service agency for cases reappearing in petitions.
- Number of suspected abuse cases referred to medical examiner or coroner for autopsy.
- Number of cases in which infant fatality results in criminal prosecution.
- Number of cases referred for criminal prosecution and outcome of prosecution.

By monitoring this type of data into the Title XX reporting and data system, without much additional cost the state and its localities can develop a "child abuse monitoring system." This monitoring system (or subsystem) would function as the management information system for policy decision-making to improve the operation of the model system, and to provide feedback to participating office on the physical and emotional aspects of child abuse. (In addition, the CIMC would provide expert witnesses to the court, e.g., psychiatrists, pediatricians, psychologists, social workers, and nurses, reimbursed by the court at its usual rate for expert witnesses.) The training and consultation activities would draw on the CIMC experience with diagnosis of child abuse cases from all sources and also ICEU experience in the initial examination process. The civil attorney's office could provide the Title XX agency with statistical data on case dispositions, using the same unique numerical identifiers, which would complete the statistical data on child abuse cases up to the point of provision of services under informal or formal court dispositions. Protective and other services provided under the terms of court dispositions also would be covered by Title XX CASP Plans and reporting requirements.

In particular, the statistical data monitoring system maintained by the designated Title XX agency would focus on the key decisions in the model system in Phase I: Identification to CIMC Intake (see Model System Chart I) and Phase II: CIMC Intake to Petition (see Model System Chart II).* The typical Title XX data reporting system would have to be slightly modified in order to monitor the decisions made by the principal decision-makers (identified in Model System Charts I and II) to provide summary data of the following types: agencies, develop training and technical assistance materials and guidelines, prepare public and professional education and training information related to improving performance of the system and its components, and prepare budgetary and legislative materials and documentation.

In order to ensure accountability to the public for system performance, the legislative and executive branches of state government should jointly appoint members of a statewide citizen's advisory board on child abuse, with overlapping terms, to be composed of persons who have established records of distinction as vigorous advocates for equal rights and opportunities for children. The board should be charged with responsibility for overseeing implementation of the model system and authorized to obtain reports and data from the Title XX agency as necessary to fulfull its responsibilities. The Child Abuse Information and Records Committee* ideally should be constituted as a subcommittee of this citizen's advisory board.

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*See: Part III, Chapter IX, Model System Decision-Making Guide.

At least 90 days before the beginning of the state's fiscal year, the Title XX agency should prepare and submit to the Governor and the Legislature an annual report on progress in implementing the model system for handling child abuse, including a full analysis of relevant statistical and performance data, and its recommendations for legislative, administrative, and budgetary actions to deal with problems and shortcomings of the system.* The annual report should provide the basis for revisions of the CASP Plan and reporting and planning requirements under the Child Abuse Prevention and Treatment Act. The citizen's advisory board should be legislatively authorized to participate in preparation and evaluation of the annual report and materials prepared pursuant to the preparation of dissenting opinions for inclusion in these documents wherever appropriate.

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*See: Part I, Chapter II, E, 2, b, 1.

*The title XX law requires a public review and comment period of at least 45 days for the annual state CASP Plan.

NOTE

(1)Child Welfare League of America, Inc., "Using Title XX to Serve Children and Youth" (1975).

This handbook includes a description of how the Title XX planning and funding process can be used to develop a comprehensive emergency services program modeled after the Nashville CES.

The Children's Defense Fund, "TitleXX/How to Look at Your State's Plan for Social Services: A Child Advocate's Checklist" (1975); Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare, "Social Services '75, a Citizen's Handbook, Program Options and Public Participation Under Title XX of the Social Security Act."

PART 3

FRAMEWORK AND GUIDE FOR CHILD ABUSE DECISION-MAKING

CHAPTER VIII. DETAILED COMPARISON OF EXISTING AND PROPOSED MODEL SYSTEMS FOR HANDLING CHILD ABUSE INTERVENTION

A. Initial Suspected Child Abuse Intervention System and Procedure

The handling of child abuse cases, from initial identification by public agencies, professionals, hospitals, or citizens, to the initiation of court process involves six areas of laws, subsystems, and practices.

First, there is the legal framework for state intervention which consists of explicit and implicit conceptions of the purposes and goals of intervention, the rights of children and parents, and the definition of abuse which reflects these philosophical and legal concepts and sets the boundaries for law enforcement and judicial jurisdiction.

Second, there are the legal and procedural prescriptions as to who shall report to whom, by what means, with what types of legal protections and obligations consequent to the report.

Third, there is the information system for receiving, processing, utilizing, and disseminating information reported, provision for access to, modification and removal of information retained in the system, and provisions for safeguarding confidentiality of the information in this information system and ancillary recordkeeping systems or files.

Fourth, there are the procedures for investigation and verification of suspected child abuse reports and the roles played by justice system and non-justice system agencies in carrying out these procedures.

Fifth, there are the medical and other types of systems, procedures, and techniques utilized to diagnose the suspected injuries as part of the verification process. Under the existing system, investigation, verification, and examination activities frequently are combined with service and treatment activities which may result in diversion of the case from the justice system and informal handling by public or private community service agencies.

Sixth, there are the laws, legal and agency procedures and practices pertaining to protective custody of endangered children, in their own homes or in substitute homes or other residential facilities, under court order, and voluntary placement activities handled by public or private social service agencies in lieu of court action.

In the series of Charts A-F: Comparison of the Key Provisions of the Present and Proposed Systems of Handling Child Abuse that follow, we have attempted to generalize and summarize the key provisions of the present child abuse handling system in the six areas outlined above and to compare them with the proposed provisions of the model system for the initial intervention stage (i.e., up to the decision to refer or not to refer a case for filing of a petition). Under the model system, we have broken the initial intervention stage down into two phases: Phase I: Identification (of a suspected child abuse case) to Intake of the Child Injury Medical Center (CIMC); and Phase II: CIMC Intake to the Petition (i.e., decision to refer or not to refer a case for filing of a petition).

In Chapter IX, we present a series of two charts which outline the decision-making process of the model system in these two phases. Model System Chart I, covering Phase I: Identification to CIMC Intake; and Model System Chart II, covering Phase II: CIMC Intake to Petition, specify the key decisions to be made, the appropriate decision-maker, and the criteria/guidelines for making the decision. The sequence of decisions in these two charts, and the decision-making options at each decision point, are graphically presented in Flow Chart I: Child Abuse - Identification to Petition.

The following Charts A-F, which compare the present and proposed systems for handling child abuse, are preceded by an outline as an aid to ready reference to the reader.

Outline of Charts A-F: Comparison of the Key Provisions of the Present and Proposed Systems of Handling Child Abuse

A. Legal Framework

- 1.0 Purpose and Goals of State Intervention
- 2.0 Rights of Children and Parents
- 3.0 Definition of Abuse
  - 3.1 Neglect
  - 3.2 Sexual Abuse
  - 3.3 Emotional Abuse Mental Abuse
  - 3.4 Accusatory/Non-Accusatory

B. Reporting

- 1.0 Form
- 2.0 Reporters
  - 2.1 Mandatory
  - 2.2 Discretionary
- 3.0 Report Recipient(s)
- 4.0 Report Content
  - 4.1 Initial
  - 4.2 Updated
- 5.0 Immunity for Reporters
- 6.0 Penalties for Failure to Report
- 7.0 Abrogation of Privileged Communication
  - 7.1 Husband-Wife
  - 7.2 Professional-Client
- 8.0 Admissibility of Report as Evidence
- 9.0 Measures to Encourage Reliability in Reports

C. Central Registry/Information System

- 1.0 Purpose
- 2.0 Location
- 3.0 Source of Reports/Means of Reporting
- 4.0 Scope of Reports Recorded
  - 4.1 Physical Abuse
  - 4.2 Sexual Abuse
  - 4.3 Neglect
  - 4.4 Emotional Abuse/Mental Injury
- 5.0 Scope of Information in Reports
- 6.0 Information Included in Central Registry
  - 6.1 Initial/Update/Termination Reports
  - 6.2 Additional Information from other Sources
- 7.0 Classification of Information
  - 7.1 Verfication Result
  - 7.2 Passage of Time
- 8.0 Modification of Information
  - 8.1 Provisions for Expungement
  - 8.2 Sealing and Unsealing of Records
  - 8.3 Amendment or Removal of Information
- 9.0 Access to Information

- 9.1 Persons Permitted Access
  - 9.2 Means of Access
  - 9.3 Access by Subject
  - 9.4 Rights of Subject to Hearings on Content of File
- 10.0 Confidentiality of Other Records in System
  - 10.1 Access to Records:
    - 10.11 Child Protective Agency
    - 10.12 Police/Law Enforcement
    - 10.13 Physician/Hospital
    - 10.14 Treatment, Service, or Supervision Agency
    - 10.15 Court
    - 10.16 Legal Counsel for Parent, Child (Guardian ad Litem)
    - 10.17 Grand Jury
    - 10.18 State or Local Officials
    - 10.19 Researchers
    - 10.20 Public Reporters
  - 10.2 Provisions for Release of Records
  - 10.3 Safeguards for Use of Records
- 11.0 Statistical Data Collection and Analysis

D. Investigation and Verification of Child Abuse

- 1.0 Agency Responsible
- 2.0 Time Allowed for Investigation
- 3.0 Scope
  - 3.1 Environment of Child
  - 3.2 Identity of Siblings
  - 3.3 Risk to Child and to Siblings of Remaining in Home
  - 3.4 Extent of Injury
  - 3.5 Cause of Injury
- 4.0 Procedure
  - 4.1 Notice
  - 4.2 Search and Seizure
  - 4.3 Interview/Interrogation
- 5.0 Role of Public Agencies
  - 5.1 Protective Services
  - 5.2 Police
  - 5.3 Probation
  - 5.4 District Attorney
- 6.0 Report to Central Registry
  - 6.1 Within What Time Period
  - 6.2 Content
    - 6.21 Initial
    - 6.22 Progress/Verification

E. Examination of the Injured Child

- 1.0 Roles of Intervening Agencies
  - 1.1 Law Enforcement
  - 1.2 Protective Services
  - 1.3 Hospital/Physician
  - 1.4 Schools
  - 1.5 Other Agencies

- 2.0 Emergency Temporary Protective Custody (Hospital)
    - 2.1 Standards and Criteria
    - 2.2 Extension of Emergency Custody
- 3.0 Examination of Injuries
    - 3.1 Injuries to be Examined
    - 3.2 Home Examination
    - 3.3 Referral to Hospital/Clinic/Physician
    - 3.4 Medical Diagnosis and Decisions
- 4.0 Psychiatric/Psychological Examination
    - 4.1 Child
    - 4.2 Parents
- 5.0 Access to Information in Other Agencies
- 6.0 Legal Rights During Examination Process
    - 6.1 Parents
    - 6.2 Child
- 7.0 Multi-disciplinary Team

F. Protective Custody

- 1.0 Removal Criteria
- 2.0 Removal Procedures
- 3.0 Use of Detention
- 4.0 Use of Hospital
- 5.0 Emergency Services
- 6.0 Use of Foster Care
- 7.0 Court Hearing
    - 7.1 Notice
    - 7.2 Time Elapsed
    - 7.3 Legal Representation
- 8.0 Limits on Duration of Protective Custody
- 9.0 Measures to Encourage Contact between Parents and Child

A. LEGAL FRAMEWORK

	Present System	*Proposed System*
1.0 *Purpose and Goals of State Intervention*	As defined in state civil or criminal codes, the purposes of state intervention are to prevent harm and to protect the child, to provide protective services, to serve the welfare or best interests of the child or the state, and to treat the family unit. The purposes of state intervention are most often found in neglect clauses of civil codes and, in half the states, in the reporting clauses of civil codes and, to a lesser extent, in criminal codes reporting statutes. Katz (*Family Law Quarterly*, Vol. IX, No. 1, Spring 1975, pp. 53-54) regards Connecticut's civil reporting clause as typical: ". . .to protect children whose health and welfare may be adversely affected through injury and neglect. . .to strengthen the family and to make the home safe for children by enforcing parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children by enhancing parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary and for these purposes to require the reporting of suspected abuse, investigation of such reports by a social agency, and provision of services, where needed to such child and family. (Conn. Rev. Stat. Ann. §17-38a)	Coercive intervention by the state in suspected child abuse cases should be limited to achieve specified goals to protect children from specific serious harm. The types of harm should be sufficiently serious as to outweigh the potentially detrimental effects of available coercive remedies, especially child removal. The processes of intervention should likewise be limited to comport with the limited aims of classes of harms warranting intervention. Help and protections, both of which are relatively scarce commodities for children and our society, should be dispensed in concentrated doses to those most in danger. The focus of intervention, protection, treatment remedies, etc. should be the child. Coercive intervention under child abuse statutes should be limited to actual physical injury caused nonaccidentally or in an abnormal manner. When there is *likely to be* serious physical injury inflicted on a child or a child is suffering from or likely to suffer from severe emotional damage, sexual abuse, serious medical neglect, or other categories of serious harm, these should be dealt with by state authorities under neglect statutes (which also should be based on the same principles of and rationale for state intervention). In other words, in cases where there is "substantial risk" that parental/caretaker action may cause serious injury, state intervention should be under neglect statutes. (See Wald, Michael, "State Intervention on Behalf of Neglected Children," *Stanford Law Review*, Vol 27, No. 4, April 1975).
2.0 *Rights of Children and Parents*	The purpose of civil and criminal statutes pertaining to child abuse is to safeguard and protect their well-being and interests, not to enforce their rights. Implicitly these laws limit parental control in recognition of the physical and psychological needs of children which, when violated, may require assertion of state control. The laws imply that children have interests and rights independent of their parents, but do not imply that children have interests independent of the state. The "best interests" standard, therefore, is explicitly the standard for adjudicating children's interests in civil abuse and neglect proceedings evaluating parental care. The rights of children are least clear in terms of state intervention, where offensive parental behavior does not result in medically diagnosable harm to the child.	At the point at which a parent requires counsel, because the parent-child relationship may be seriously disturbed, a child has a right to equal party status since its rights also may be adversely affected. As soon as the state and its authorized representatives initiate a process that may challenge the fitness of parents for parenting, by temporary or permanent removal of their child, the parents probably are in conflict with the state, and the state may be in conflict with both parent and child. The child immediately requires representation by counsel as the most effective form of recognition of the child as a person in his/her own right. The child should have the right to an interpretation of his/her own interests (e.g., physical and psychological well-being) independent of the parents' judicial, administrative and other decision-makers. The function of counsel of advocate in child abuse cases should be (e.g., guardian ad litem) to ensure as a matter of legally recognized right, that state intervention is sufficient to protect the child from serious harm, is minimally disruptive to parent-child relationships, and results in "the least detrimental available alternative." (See Goldstein, Joseph; Freud, Anna; and Solnit, Albert, *Beyond the Best Interests of the Child* (New York, The Free Press, 1973).

A. LEGAL FRAMEWORK—Continued

	Present System	*Proposed System*
3.0 *Definition of Abuse*	Usually any non-accidental or serious physical injury, but often broadened to include neglect, sexual abuse, and, in some states, emotional abuse. The trend is toward broadening of definition of abuse to include neglect, sexual abuse and emotional abuse or mental injury.	Actual serious physical injuries inflicted by a parent or caretaker or occurring in an abnormal manner. Determination of abuse is based on the type and severity of the injury and comparison of the parents' or caretakers' explanation of the injury with its nature. Physical punishment that leads to serious injuries requiring medical treatment would qualify as abuse. (See Green, Judith, "Intervention between Parent and Child: A Reappraisal of the State's Role in Child Neglect and Abuse Cases," *Georgetown Law Journal*, Vol. 63, No. 4, March, 1975.)
3.1 *Neglect*	Almost always included.	Not included. When there is *likely to be* serious physical injury inflicted on a child, this situation would be dealt with under neglect status. Also, failure to provide medical care when a child is suffering serious physical injury or emotional damage, and failure to thrive.
3.2 *Sexual Abuse*	Often included.	Not included. Proposed to be covered under neglect statutes.
3.3 *Emotional Abuse/ Mental Abuse*	Often and increasingly included.	Not included. Proposed to be covered by neglect statutes under specific and narrow standards for intervention.
3.4 *Accusatory/ Non-Accusatory*	Most often accusatory in the sense of identifying the perpetrator of abuse; less often accusatory in terms of providing for criminal prosecution of the perpetrator.	Accusatory in the sense of requiring a medical and legal determination of non-accidental injury inflicted by a parent or caretaker; non-accusatory in the sense that (1) the focus is on the consequences resulting from parental action, not the fault or guilt of the perpetrator, and (2) criminal prosecution for the perpetrator is eliminated except in the instance of death of the child.

B. REPORTING

	Present System	*Proposed System*
1.0 *Form*	Most frequently oral, with written follow-up reports required in many states.	24-hour, 7-day telephone lines, including WATS lines, located in the Injured Child Examination Unit (ICEU). Written report from the ICEU to the hospital (Child Injury Medical Center) in cases of referral, from a physician to the hospital in cases of referral, from the hospital to the ICEU in cases examined for inflicted injuries (not referred by the ICEU) and from police to the hospital in cases of emergencies.
2.0 *Reporters*		
2.1 *Mandatory*	Physicians in all states; nurses and social workers in a majority of states; teachers and police officers in some states. The trend is toward expanded classes of mandated reporters.	Physicians are obligated to refer suspected child abuse cases to a designated Child Injury Medical Center (CIMC). Hospitals are obligated to refer suspected child abuse cases to a CIMC or to report their examination of such cases to the local Injured Child Examination Unite (ICEU); CIMC's are obligated to report their examination of suspected abuse cases to the local ICEU. Law enforcement officials are obligated to report suspicious child injuries to the local ICEU. When a child has died as a result of physical abuse, other maltreatment or unexplained causes, including possible Sudden Infant Death Syndrome, a report should be made by the law enforcement agency, physician or hospital to the appropriate medical examiner or coroner, who should report his findings to the law enforcement agency, district attorney and, if reported by a hospital, to the hospital.
2.2 *Discretionary*	Most other professionals coming into contact with children, as well as private citizens.	All other professionals, agencies and citizens should refer or report cases of suspected child abuse to a CIMC or a ICEU.
3.0 *Report Recipients*	Most frequently state, county, or local departments of public welfare (protective service units), or local police department. Occasionally court, hospitals, or public health departments.	Injured Child Examination Unit (ICEU) of public health agency, or law enforcement agency where serious abuse requires emergency removal of a child from the home for hospitalization.
4.0 *Report Content*		
4.1 *Initial*	Often such minimal information as name of child and parent, location or home address, and description of injuries or other reasons to suspect abuse, and, optionally, name of reporter.	Name age, and address of the injured child, name of the parent/caretaker, identity of reporter, description of injuries, and date of report.
4.2 *Updated*	Not required in all states. Where required, includes elaboration of identifying information, nature of injuries, action taken in the case, and sometimes whether the case has been validated.	Initial report not updated for purposes of ICEU records. (For nature of additional records which accrue in a case, see Chart C. 5.0-6.0.)
5.0 *Immunity for Reporters*	Immunity from civil or criminal liability is provided in every state in some form; a majority provide immunity from both civil	Immunity from criminal and civil actions resulting from a good-faith report of child abuse.

B. REPORTING—Continued

	Present System	*Proposed System*
5.0 (Cont'd.)	and criminal actions. A majority of states stipulate that the report must have been made "in good faith and without malice" for immunity to be operative.	Immunity from civil and criminal liability should extend to any person acting in good faith for any act permitted or required in the proposed system, including, but not limited to, reporting, placing a child in protective custody, participating in court hearings, taking photographs or X-rays, examining the injured child, and gathering appropriate evidence.
6.0 *Penalties for Failure to Report*	Over half of the states impose criminal penalties for failure to report by mandated professionals, ranging from misdemeanor penalties to imprisonment and a fine. Civil liability, predicated on the doctrine of negligence, may also attach to statutes providing for criminal penalties for failure to report.	None. Reports encouraged through public and professional education and improvement of child abuse handling system. Civil liability for failure to report exists in all states either by specific legislation or under the doctrine of "negligence per se." Failure to comply with the provisions of the model system enacted into law would raise the presumption of negligence for any party specified in the law.
7.0 *Abrogation of Privileged Communication*		
7.1 *Husband-Wife*	A narrow majority of states void privileged communication between husband and wife.	Husband-wife privilege will run to the party testifying. That is, if the spouse of the parent suspected of abusing a child chooses to testify, it is the spouse's privilege to do so; conversely, it is also the spouse's privilege to refuse to testify.
7.2 *Professional Client*	Doctor-patient privilege is waived in 36 statutes; eleven states void all except the attorney-client privilege. The remaining 31 states void one or more privileged relationships. The legislative trend is to void all privileged relationships except the attorney-client relationship.	Not to be abrogated.
8.0 *Admissability of Report as Evidence*	This issue is not directly addressed in most state legislation.	Any information included in the report to the ICEU or to the hospital would be admissible in court.
9.0 *Measures to Encourage Reliability in Reports*	Most states engage in some form of public information and education regarding child abuse, in conjunction with reporting laws, either with selected professional groups (physicians, police, social workers, teachers) or with the public. There are no penalties for malicious submission of false reports.	Education of professionals and the public as to the existence and nature of child abuse, the availability of the telephone reporting system, the methods for handling suspected child abuse cases, and the requirement that reports be made in good faith to avoid liability in cases of deliberately false or malicious reports.

C. CENTRAL REGISTER/INFORMATION SYSTEM

	Present System	*Proposed System*
1.0 *Purpose*	Four functions are commonly presented for establishment of central registers (1) compilation of statistical information to ascertain the true incidence of child abuse; (2) information to assist in research into the nature and causes of child abuse; (3) to assist in medical diagnosis and investigations related to court actions; (4) tracking of abusive caretakers who move from hospital to hospital or from jurisdiction to jurisdiction.	Establishment of a Child Abuse Information File (CAIF) for the limited purpose of enabling an ICEU or a hospital (CIMC) to ascertain risk to a child or release to its home or remaining in its home where injuries do not visibly appear to warrant emergency medical treatment or examination to determine possible inflicted injury, and to facilitate the investigation process after filing of a petition.
2.0 *Location*	Most frequently in the state department of public welfare, although the register function may be maintained by the criminal justice system.	In a legislatively authorized agency at the state level other than law enforcement or the judiciary, and unconnected with any other state or local computerized or centralized information system.
3.0 *Source of Reports/ Means of Reporting*	Usually the mandated recipient of child abuse reports; most commonly departments of public welfare and police departments. Means of submitting reports include telephone transmission and submission of written reports by mandated professionals.	Hospital (CIMC): Information concerning cases referred for petition. County Attorney: Information concerning cases in which a petition is filed. Courts: Information concerning the outcome of all child abuse proceedings. District Attorney: All cases involving death of a child prosecuted under child abuse or criminal statutes, irrespective of the judicial outcome. Means of reporting are written reports, which are verified for accuracy.
4.0 *Scope of Reports Recorded*	The majority of states which maintain central registers accept reports regarding all forms of harmful activities to children, in keeping with the broad mandate for reporting: physical abuse, sexual abuse, neglect, and, as often, emotional abuse or mental injury. As the definition of abuse used in reporting laws expands, so too does the scope of reports submitted to central registers.	Physical child abuse only, under the restricted definition presented in A. 3.0 above. Physical Abuse - Included if within restricted definition. Sexual Abuse - Not included (but could be included). Neglect - Not included except for cases in which (1) the likelihood of serious inflicted injuries is adjudicated or (2) serious and willful medical neglect is adjudicated. Emotional Abuse/Mental Injury - Not included except as covered under neglect.
5.0 *Scope of Information in Reports*	Varies from minimal information necessary to meet statutory requirements (e.g. name of child, parents, address, nature of reported abuse, informant), to a comprehensive compilation of information from protective services, hospitals, schools, mental health agencies, courts, and other involved community agencies.	The names and addresses of the child, his/her parents, guardians or legal custodians responsible for the child's welfare at the time of the incident; child's age, sex, and race; the date and source of the report; type of action taken by reporter (report or referral to ICEU or CIMC; examination by ICEU, CIMC or other hospital); type of court action (petition adjudicated; disposition; ratification of medical examiner/coroner; report by medical examiner/coroner to D.A.; criminal prosecution; charge adjudication, disposition; disposition in civil or criminal proceeding terminated).
6.0 *Information Included in Central Regist*	Essentially the same information as included in initial reports with some states updating information in the initial report from various sources.	Child Abuse Information File (CAIF) retains information indicated in 5.0 only when legal action culminates in an informal disposition or an adjudication and disposition in civil or criminal court, and updated to include termination of the disposition.

C. CENTRAL REGISTER/INFORMATION SYSTEM—Continued

	Present System	*Proposed System*
7.0 *Classification of Information*	Provisions are seldom made for classification of confidential information, verification of reports in central registries, or for special handling of reports retained for specified periods of time. (See 8.0)	The Child Abuse Information and Records Committee (CAIRC) in each state shall establish minimum standards for the classification of information in the CAIF with respect to retention, use, access, and dissemination for each type of information and each type of potential user, including civil remedies for improper information handling.
8.0 *Modification of Information*	Most states currently maintaining central registers do not make provision for modification of information in the register, except addition of information by the reporting agency or other agencies.	Rules and regulations, reviewed and approved by the CAIRC, for procedures to challenge the correctness and modify the content of information in the CAIF or any of its sources, would be promulgated in each state.
9.0 *Access to Information*		
9.1 *Persons Permitted Access*	Most frequently the agency submitting reports, hospitals and physicians for purposes of diagnosis of child abuse, law enforcement officials and courts.	Law enforcement officers, designated ICEU staff, CIMC staff; during the petition investigation process or post-petition; city or county attorney; district attorney in connection with criminal decision-making process on suspected or alleged child abuse.
9.2 *Means of Access*	Computerized entry where the system is computerized, by "authorized" users; written or oral request for information to the maintaining agency.	When a suspected child abuse case is being examined by ICEU staff, the police or ICEU staff would contact the CAIF or, if after hours, the next day; if the ICEU refers this case to a CIMC, notations on the CAIF record would be included with the referral. If the CIMC decides to refer the case for a petition or criminal action is pending, the city or county attorney or the D.A. may request of the CAIF that a copy of the record be sent to them.
9.3 *Access of Subject*	Provision for access by the subject to his own file is not made by most states maintaining central registers (possibly by none). Theoretically, the Freedom of Information Act might allow access if the subject is sophisticated enough to pursue the matter.	The subject of a CAIF file or any records pertaining to them in the files of other agencies would have access to all information in those files, including the source of reports (by agency), at any time, in the same form as it would be provided to any person authorized in 9.1 to obtain such information. The procedure for access to the CAIF should be simple, requiring only presentation of a vilid form of identification by the subject or a legal representative to the clerk of the court maintaining the CAIF and the signing of an official written request form. Each subject should be automatically notified that the CAIF has a right to challenge the accuracy of the information, and a right to add their own comments to the record.
9.4 *Rights of Subject to Hearings on Content of Files.*	This right does not exist in any state at the present time.	Each subject should have the right to a hearing, to challenge the correctness of any information in the CAIF, before an official of the court who has the authority to make any corrections that result from the challenge. The rules and regulations for such a hearing process should be transmitted to each subject along with the information specified in 9.3. These rules and regulations would have to be reviewed and approved by the CAIRC (see 8.0).

C. CENTRAL REGISTER/INFORMATION SYSTEM

	Present System	*Proposed System*
10.0 *Confidentiality of Other Records in System*		See 7.0 and II.A.9.b. (4)-(10) which specifically pertain to CAIF information but also to confidentiality provisions pertaining to all information and records on child abuse cases collected, retained or utilized by any state or local agency.
10.1 *Access to Records*		See 9.0-9.4 and II.A.9.b. (4)-(10) which specifically pertain to CAIF information but also to access to provisions to all information and records collected and retained by any state or local agency pertaining to child abuse cases.
10.11 *Child Protective Agency*	Frequently share information with other community agencies, either formally through transmission of written materials, or, more frequently, informally through discussion by caseworkers with representatives of other community agencies.	Access to CAIF data is through contact with ICEU or police in emergency situations. (It is assumed that emergency child injury cases would involve calls to police for transportation to a CIMC.)
10.12 *Police/Law Enforcement*	More restricted sharing of information with more stringent controls. Primarily shared with courts and with other community agencies under specified conditions, such as a formal agreement for sharing of child abuse reports.	Access to CAIF data on non-emergency calls where ICEU worker is not available for any reason. (It is assumed that emergency child injury cases would be transported to a CIMC.)
10.13 *Physician/ Hospital*	Usually stringent controls on confidentiality of information, abridged for court processes (often under subpeona); and increasingly under informal conditions in multi-disciplinary team case conferences, where medical, social, and legal information may be shared.	Physician would have access to CAIF through ICEU. Hospitals/medical facilities would have access to CAIF through ICEU or CIMC.
10.14 *Treatment, Service, or Supervision Agency*	Information shared under formal and informal conditions with law enforcement and police, and with other community agencies such as schools, mental health agencies, and public/private protective service agencies.	No access to CAIF except by case referral to ICEU or CIMC.
10.15 *Court*	Usually formalized conditions for the sharing of information, with some due process safeguards. Often provisions are stretched during the "informal" negotiation process characteristic of civil handling of child abuse cases. May obtain information through subpeona powers.	CAIF data maintained in district, juvenile, or family court, with strict provisions for access and dissemination.
10.16 *Legal Counsel of Parent, Child (Guardian ad Litem)*	Attorney-Client privilege is not abrogated in child abuse cases. Information shared informally during the treatment-oriented informal negotiation process is characteristic of civil handling of child abuse.	Same as present system.
10.17 *Grand Jury*	Through subpoena powers has access to most or all community records and witnesses. Shares information with court sys-	Same as present system.

C. CENTRAL REGISTER/INFORMATION SYSTEM—Continued

	Present System	*Proposed System*
10.17 (cont'd.)	tem according to legal due process standards.	
10.18 *State or Local Officials*	See 10.11 and 10.14. Essentially the same procedures pertain to state and local officials with "legitimate interests."	Only city/county attorneys or the District Attorney in connection with handling current legal process for child abuse cases.
10.19 *Researchers*	Often granted access to local and state agency records and to central registry information, sometimes after examination of the purposes of research by some state representative.	Provisions for access to CAIF information or any records pertaining to child abuse in any state or local agency shall be governed by rules and regulations promulgated by the Child Abuse Information and Records Committee, incorporating standards for approval of the subject, where identifiable records are involved, specified in I.B. 4.b.
10.20 *Reporters*	Access to public information in police and court records. Theoretically no access to information in community agencies including protective services, hospitals, schools, or mental health agencies.	Only law enforcement officials and authorized ICEU and CIMC staff, among reporters, would have access to CAIF data. Access by reporters to records on child abuse cases in other state and local agencies would be subject to the same restrictions as any other party (see 7.0).
10.2 *Provisions for Release of Records*	See 10.11-10.15. Essentially the same procedures pertain to release of records.	Release would be restricted to persons authorized access under 9.1, the subject, and persons authorized by the subject or his/her legal representative.
10.3 *Safeguards for Use of Records*	Formal release of child abuse records by state agencies is usually governed by specific departmental policy. Informal release of information is less stringently governed.	Rules and regulations promulgated and monitored by the CAIRC, limitations on the type of information collected, the circumstances under which information would be retained, limitations on access, utilization and dissemination, provisions for subject challenge, modification and approval (e.g., research purposes) expungement provisions, information system design review approval requirement, and the functions of the Child Abuse Information and Records Committee collectively constitute the provisions for safeguards in the model system.
11.0 *Statistical Data Collection and Analysis*	Little consistent statistical data is collected by police, courts, or public welfare agencies regarding the number of reports, verified instances, or disposition of cases of child abuse. Cross-jurisdictional comparison is impeded by differing definitions and categories of abuse and dispositions. Analysis is limited by inadequate or incomplete data. The American Humane Association's Clearing House on Child Neglect and Abuse has produced a one-page form to collect case information from some states so that incidence, characteristics and disposition data can be gathered nation-wide.	The data collection, reporting and monitoring requirements of Title XX of the Social Security Act would include specific statistical reporting requirements from agencies handling suspected child abuse cases within the model system. No identifying information would be reported by these agencies to the designated state Title XX agency. By using unique numerical identifiers for each case, assigned to the case by the ICEU or CIMC, the services for and activities related to handling of child abuse cases, from initial identification to court disposition, can be tracked and documented to monitor system performance and cost. Each agency in the model system can receive reports and analyses of overall system performance, including data on the activities of their agency. This data would be made available to the state child abuse advisory committee for the purpose of preparing recommendations for legislative, executive and judicial review and as input to the Title XX Comprehensive Annual Service Program Plan, on a statewide, regional and local basis.

D. INVESTIGATION AND VERIFICATION OF CHILD ABUSE

	Present System	*Proposed System*
1.0 *Agency Responsible*	Currently three agencies share responsibility for investigation and verification of child abuse: police departments, protective service agencies (public and private), and probation departments of courts.	Initial examination (as distinct from investigation) of suspected child abuse will be performed by the ICEU (if at home), or by the CIMC if the case is detected at or brought to a medical facility initially. Police, at their discretion, may investigate such cases in which criminal charges may be brought.
2.0 *Time Allowed for Investigation*	There seldom are stated limits on the amount of time that may be devoted to a child abuse investigation. Constraints are imposed by availability of personnel to conduct the investigation. It is not uncommon for there to be considerable delays between reporting of a suspected child abuse case (and even emergency removal of the child) and initiation and completion of the investigation.	The initial medical examination and diagnosis must be completed within 96 hours or a court hearing to extend hospital custody must be held. In any event, medical diagnosis sufficient to allow referral to the local civil counsel or closing of the case by the CIMC must occur within 7 days. (See "E" below.) The local counsel may conduct a further pre-petition investigation before deciding whether to file a petition in civil court; that investigation is limited to 3 days.
3.0 *Scope*		
3.1 *Environment of Child*	The child's environment is usually a major element of the investigation, including the condition of the home, the parents' adequacy as homemakers, facilities and resources in the home, social habits of the parents, persons having access to the child, and any other aspects of the home environment that may be of interest or concern to the investigator.	Home environment is examined at the post-adjudication stage of court process, as necessary for determining dispositional alternatives.
3.2 *Identity of Siblings*	Identity of siblings is generally included in any social investigation pursuant to a report of child abuse. Futher, there may be record-checks to determine whether siblings have been subjected to neglect or abuse, and/or the medical history of siblings.	The ICEU or the CIMC may obtain identity of siblings to aid in checking previous medical and CAIF records. Identity of siblings will also be obtained in the pre-petition investigation.
3.3 *Risk to Child and to Siblings of Remaining at Home*	It is the purpose of the investigation to determine risk to the child (and to siblings), as well as to establish whether abuse occurred at all. Determination of risk requires a substantial degree of judgment on the part of the investigator in interpreting information obtained in the investigation.	Risk is a legal judgment made either at a preliminary custody hearing or at the adjudication and dispositional hearings when a petition is filed. It is not a judgement to be made by investigators, although information collected by investigators may be used to formulate the decision.
3.4 *Extent of Injury*	Extent of injury usually is determined through medical examination of the child; this may be performed by a trained child abuse team if one is available in a hospital in the locality.	Extent of injury is determined through medical diagnosis and testing at the CIMC.
3.5 *Cause of Injury*	It is one purpose of the investigation to reach a conclusion regarding the cause of injury, and specifically whether the injury was inflicted by parent/caretaker or some other person in a caretaker role.	Parents' explanation of the cause of injury may be elicited as part of the standard medical history obtained at the CIMC. Further determination of cause of injury occurs only in the context of civil court process.

D. INVESTIGATION AND VERIFICATION OF CHILD ABUSE—Continued

	Present System	*Proposed System*
4.0 *Procedure*		
4.1 *Notice*	Although practices vary, parents are not necessarily given notice that discussion regarding their child's injuries may eventually be used in a civil court process. Nor are they customarily informed of their right to remain silent, except in the event that criminal prosecution has been initiated.	Parents are provided notice that the cause of their child's injuries is in question, and that court proceedings may ensue, when CIMC staff first suspect that injuries may have been inflicted. (See E below). At that time, parents are informed that they may remain silent, that any information they provide may be used in court proceedings, and that they have a right to counsel.
4.2 *Search and Seizure*	Police may conduct a search and seize objects considered to be pertinent to criminal prosecution as evidence. In general, the purposes are (1) to obtain the "fruits" of the crime, (2) to obtain the instrumentalities of the crime, (3) to obtain evidence establishing the commission of a crime. In general, searches *incident* to a lawful arrest are permitted without the formal requirement of a search warrant. Certain exigent circumstances occasionally are recognized to justify warrantless searches and seizures either incident to or prior to an arrest. These include: (1) the "plain-view" exception which permits the seizure of objects without a warrant when these are within the plain view of an officer and (2) emergency circumstances in which the evidence to be seized could be destroyed or carried off in flight before a warrant can be obtained.	There is no search and seizure at the child's or caretaker's home at any stage of the model system process.
4.3 *Interview/ Interrogation*	Parents, siblings, relatives, friends and neighbors may be interviewed in the investigation as possible witnesses in a civil or criminal process, or as part of determining fitness of the home and future risk to the child in the home.	Parents and child are interviewed on a limited basis by ICEU and CIMC staff in the initial stages of examination of the child. Further interviewing of family members or other persons will not occur until a pre-petition investigation or subsequent stages of the court process.
5.0 *Role of Public Agencies*		
5.1 *Protective Services*	In some jurisdictions, protective services has major responsibility for conducting the abuse investigation. Protective services may serve the role otherwise performed by *probation departments, providing social* information to be used at adjudication and dispositional stages of civil court process.	Protective Services plays no role in the investigation of suspected child abuse cases at any stage. Their role is limited to provision of services on an emergency basis after contact by the ICEU or CIMC during court process or on a continuing basis as needed as part of the dispositional plan.
5.2 *Police*	It appears that the incidence of criminal prosecution is dependent, among other factors, on how extensive is the role of the police in the identification and investiga-	Police are involved in investigation only insofar as they may determine whether a child's life and safety are endangered, constituting a medical emergency and thus requiring emergency removal. Police may

	Present System	*Proposed System*
5.2 (Cont'd.)	tion of possible incidents of child abuse. In some jurisdictions, it's a preferred policy for police to refer discovered child abuse cases to the appropriate social agency for followup. In other jurisdictions, based on either a policy decision or a lack of an alternative resource, police are relied upon to conduct the investigation, especially where resistance from the family is involved. In general, the more severe cases on physical abuse and sexual abuse will be pursued by the police as a criminal matter, often in conjunction with civil proceedings. Arrests when made either pursuant to a criminal child abuse law or other criminal statute are made on the basis of probable cause, with or without a warrant (according to the law of arrests) and either after or before a criminal indictment or information has been filed. If the abuse results in a serious injury (e.g., death), or if it involves sexual abuse, arrest and criminal prosecution will result. Probable cause is, in general, based on either the observation of circumstances or reliable knowledge of facts which would lead a reasonable man to conclude that a crime was committed and that the person to be arrested committed it.	also play a role in investigation for criminal proceedings. The police shall refer all cases coming to their attention where the death of a child has occurred and the cause is either unknown or appears to be other than natural to the coroner and the D.A.
5.3 *Probation*	Probation may perform a social investigation for use at dispositional stage of court process.	Probation plays no role in the investigation process, but rather is limited to case coordination and monitoring functions at post-dispositional stage or civil court proceedings.
5.4 *District Attorney*	The district attorney plays the primary role in the screening process of abuse cases as in other criminal matters. Preliminary screening may occur at the police investigation level, either through police discretion or by specific policy (see above) but those cases which come to the D.A.'s attention will ultimately be screened by him. In general, criminal proceedings will be initiated in cases of criminal child abuse, murder, manslaughter, first degree assault, and sexual assault or incest. Key factors which influence the decision to prosecute include the quality and quantum of evidence available, the severity of the abuse, the number of prior incidents of abuse, the determination of whether the family is reparable and the degree of noteriety the case has received. As the degree of seriousness of the abuse lessens, the evidence available increases in importance as a variable. Mild forms of abuse with marginal	The district attorney screens those cases where death of a child has resulted for possible criminal prosecution in the same manner as is presently done. Proceedings for all other types of physical abuse shall be initially commenced civilly. The city/county attorney shall screen those cases and shall, where appropriate, refer the more severe cases of physical abuse to the D.A. for possible criminal prosecution under the appropriate criminal statutes. Whenever an infant or child's death occurs and the cause of death is unknown or appears to be other than natural, the coroner or medical examiner shall perform an autopsy to determine the cause of death. The coroner's findings shall be reported to the D.A.

D. INVESTIGATION AND VERIFICATION OF CHILD ABUSE—Continued

	Present System	*Proposed System*
5.4 (Cont'd.)	available proof are less likely to be prosecuted than more serious forms of abuse with the same amount of evidence. In general, cases of murder, manslaughter, first degree assault, and sexual assault or incest are handled criminally. Less severe acts of abuse are screened out and handled civilly or informally. Other factors which affect the screening process are the quality and quantum of evidence available, the repetition of incidents of abuse and the potential for preserving the family unit intact. These same factors also affect the type of charge — felony or misdemeanor.	
6.0 *Report to Central Registry*	Most states currently require a report of suspected child abuse (and neglect) to the state register, to be submitted either by police, protective services, or court.	
6.1 *Within What Time Period*	Time periods usually include identifying information and the nature of the alleged abuse/neglect; it may also include rudimentary information concerning the social situation of the family.	Reports to the Child Abuse Information File (CAIF) maintained by the civil court, occur only in the event of civil court proceedings which result in adjudication.
6.2 *Content*		
6.21 *Initial*	Initial report content usually includes identifying information and the nature of the alleged abuse/neglect; it may also include rudimentary information concerning the social situation of the family.	The court may have internal records concerning suspected child abuse cases appearing before the court. These are *not* entered into the CAIF.
6.22 *Progress/ Intervention*	The later reports usually include additional information concerning the social situation of the family, as well as some information concerning determinations of whether abuse/neglect has been verified and possibly what services have been provided. At this point, records from other community agencies may be entered into the register. Not all states require distinction between "verified" and "unfounded" abuse/neglect reports.	Only cases which are adjudicated are entered into the CAIF.

E. EXAMINATION OF THE INJURED CHILD

	Present System	*Proposed System*
1.0 *Roles of Intervening Agencies*		
1.1 *Law Enforcement*	Law enforcement agencies often are the first agency contacted by the public in suspected child abuse and, in most states, are either the designated recipients of reports or share that role with protective service agencies. Police usually perform a standard police-style investigation of the situation for the purposes of protecting the child and gathering evidence for possible criminal or civil prosecution. They may interview parents, siblings, the child, relatives, baby sitters, and neighbors; observe and possibly search the house; confiscate any pertinent physical evidence (e.g., weapons), or photograph the home or the child; observe and assess the physical condition of the child in question; and have the authority to remove suspected child abuse victims for protection or to obtain medical treatment.	Police will continue to receive and respond to complaints or reports from citizens about suspected child abuse and emergency calls. Criminal investigation should be limited to homicides and perhaps "heinous" cases of abuse in which case investigation of the cause of deaths and injuries should follow a prescribed set of procedures. When police answer the initial report of suspected child abuse, they would contact a public health agency (ICEU) to examine the injured child except in cases requiring emergency treatment at a hospital. Police intervention should utilize principles of family crisis intervention when responding to possible child abuse cases.
1.2 *Protective Services*	Protective services agencies are the designated recipients of child abuse reports or, in some states, share that role with law enforcement agencies. Thus, they may perform the first intervention in a suspected child abuse situation, either alone, or with law enforcement or court personnel. The initial investigation performed by a protective service worker focuses on the social situation of the parents, observation of the home and the child, interviews with the child and siblings, if appropriate, and sometimes immediate intervention in the form of provision of services or removal of the child for its protection or in order to obtain medical treatment.	Protective services plays no role in the initial examination of the child in suspected child abuse cases, except in emergency cases. Otherwise they would contact the public health agency (ICEU) to make a preliminary examination of the child. They may provide emergency services if necessary, but such services should be provided voluntarily, without threat of legal action. They may be involved in provision of services after court adjudication, as part of a dispositional treatment plan, and frequently will assume case management responsibilities.
1.3 *Hospital/Physician*	A hospital enters the child abuse handling process when a child is brought to the hospital by law enforcement or protective services personnel; when a possible abuse case is detected within the hospital emergency room, outpatient clinic, or inpatient wards; or when a suspected case of abuse is referred by another physician or hospital. The hospital generally performs a medical diagnostic function. If the hospital has a child abuse or trauma team, a medical social worker also may perform some assessment of the parents' and child's psychological state, of the family's home situation, and the risk of returning the child to the home. Hospitals occasionally also par-	State-licensed Child Injury Medical Centers (CIMC) perform the medical diagnosis necessary to establish whether physical abuse may have occurred, and whether a referral should be made to the city/county attorney for a petition to civil court. Elements of the diagnosis may include routine blood surveys, radiological bone surveys, examination of any tissue trauma (burns, bruises, cuts, etc.) and any other laboratory procedures deemed necessary. The CIMC may consult the Child Abuse Information File to determine whether there is any record of previous abuse in the family which resulted in court action.

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
1.3 (Cont'd.)	ticipate in the development of treatment plans for families in which abuse may have occurred.	
1.4 *Schools*	Except insofar as they may provide referrals to police or protective services (provide records to other agencies engaged in investigation of suspected child abuse cases*), schools generally do not play an active role in the investigation of suspected child abuse. School personnel may perform internal preliminary investigations of the home situation of students who are subjects of concern; once a report has been filed with the mandatory recipient of suspected child abuse reports, however, school investigatory activities usually cease. *Note that the recently enacted Family Educational Rights and Privacy Act will prohibit provision of school records in suspected abuse cases to other agencies without explicit parental consent.	Public health agency staff (ICEU) would be available for examination of children in schools, to train school nurses in abuse identification, and likewise to train teachers and other school personnel.
1.5 *Other Agencies*	Probation departments of civil courts often perform an investigation in abuse cases; occasionally this function is contracted out to private or public child protection agencies, or, more often, is performed by protective services divisions of the public welfare department. In the event of criminal prosecution of child abuse, either under abuse or criminal statutes, the criminal investigations of police and district attorneys offices may become involved. In addition to these agencies, any service agency which becomes involved in the case will probably perform at least a cursory investigation (assessment) of the family situation in the initial stages of service provision.	The Injured Child Examination Unit (ICEU), comprised of public health nurses and/or paramedical personnel, will perform the initial examination of children who are injured and may have been abused. If there is an injury requiring further medical examination or treatment, the ICEU will refer the child to a CIMC. In Some cases, ICEU staff may contact the Child Abuse Information File to determine whether there is any record of previous abuse in the family which resulted in court action.
2.0 *Emergency and Temporary Protective Custody (Hospital)*		
2.1 *Standards and Criteria*	Children who may have been abused are retained in hospitals for the purpose of protection from any possible reabuse. While these principles appear to be fairly universal, determination of the necessity for protective admission to a hospital — or conversely, determination of the risk of returning the child to the home — appear to be based on a variety of factors assessed in varying ways by the treatment	The persons authorized to take emergency temporary protective custody of a child should consist of: a physician in a hospital, a police or law enforcement officer, or an ICEU worker. Removal under emergency temporary protective custody should be authorized when the child has injuries which warrant examination in a hospital, and the parents or caretaker(s) do not consent to emergency medical diagnosis and treatment; and when the injuries do not necessarily warrant medical

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
2.1 (Cont'd.)	personnel involved. Severity of injury, chronicity of injury, previous incidents of abuse, age of the child, and observed responses of the parents are factors usually included in an assessment of risk. There is no consensus as to how these factors are assessed. Severity of injury, chronicity of injury, for example, may or may not be an indication of danger to the child of reinjury.	examination and treatment but there is a substantial risk of more serious bodily injuries or death to the child, or the CAIF indicates a pervious adjudication for child abuse involving the child or a sibling. The only setting authorized for initial placement of a child with any degree of injuries should be a hospital, preferably a licensed CIMC. The CIMC may retain a child for 24 hours or until the next session of the juvenile or family court. At that time, a hearing for a Temporary Protective Restraining Order (TPRO) may be held to extend hospital (or other agency) custody of the child for 48 hours from the time of intake. Parents will be notified of this hearing and appointed counsel to represent them at this hearing.
2.2 *Extension of Emergency Custody*	Under state child abuse statutes, some form of court hearing is usually required in order to retain a child in emergency protective custody after a certain period of time (commonly 48 or 72 hours, although this varies by state). These court hearings may be *ex parte* proceedings, in which the parents are not present or represented.	At the end of 48 hours from initial consent or TPRO order, a TPRO may be obtained for an additional 48 hours, if the child is hospitalized for examination or treatment. This requires a court hearing with notice to parents, and representation of parents and child by counsel and guardian ad litem. Alternatively, parents may consent to an additional period of 48 hours of hospitalization of the child. If further retention of custody of the child is required beyond 96 hours, there must be an Interim Custody Hearing with all parties present to determine custody for an additional 72 hours. This occurs only if a petition has been filed, or the case has been referred to the county/city attorney for a pre-petition investigation.
3.0 *Examination of Injuries*		
3.1 *Injuries to be Examined*	Any injury of a child which is inconsistent with the explanation provided as to how it occurred, and specific kinds of injuries which tend to be associated with inflicted injury may be cause for an inflicted injury examination. Examples of the latter include multiple bruises, bone fractures on a child below a certain age, subdural hematoma, and other distinctive injuries which are unlikely to occur accidentally. Physical injury as a byproduct of sexual molestation, and physical evidence of neglect also are commonly evaluated medically under abuse statutes.	A child is discovered or reported to have been moderately or seriously injured. The injury may or may not have been caused accidentally, and the child may be at risk of reinjury. ICEU and CIMC examination are to be focused on injuries of any nature where there may be substantial risk to the life of safety of the child. Physical punishment which leads to injuries requiring medical treatment would qualify for the child abuse examination process. Injuries to be examined include the following in varying degrees of severity: bruises, burns, head injuries, fractures, lacerations, eye injuries, and internal injuries.
3.2 *Home Examination*	Home examination of injuries to a child occur only when police, protective service workers, or other public officials are referred to a home on suspicion of abuse or neglect, and only to the extent of confirm-	A special unit of the local public health agency—the Injured Child Examination Unit (ICEU)—would receive and respond to reports of suspected abuse or child injuries of any type. In the event that emergency transportation to a hospital, or hostile

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
3.2 (Cont'd.)	ing whether there is adequate reason to suspect abuse to warrant removal to a physical or hospital setting.	behavior on the part of the caretakers is anticipated, a police officer would accompany the ICEU nurse or physician assistant to the home. The home examination is designed to perform screening of reported injuries for medical treatment or hospital referral. The ICEU must decide: (1) whether the child requires examination (and treatment) at the CIMC; and (2) whether there is imminent danger to the child's life or safety, and a need for emergency services to the family in the crisis situation. Except in crisis situations, the ICEU contacts the parents by telephone to arrange a home visit within two hours of a referral/report. If the parents refuse consent, a warrant for entry into the home and examination of the child is obtained. The ICUE must determine whether there is sufficient evidence of physical injury to the child to warrant removal for examination in the designated CIMC. This is based on nature and severity of injuries, and comparison of the injuries with the caretaker's examination of injury. If parents do not consent to removal of the child to the CIMC for examination, ICEU staff contacts the police to obtain a body warrant for such removal. The ICEU may make a voluntary referral of the parents for emergency services.
3.3 *Referral to Hospital/Clinic/ Physician*	Referral may take place as a result of police or welfare agency investigation of a report of abuse; it also may occur informally by other physicians or hospitals, or as an internal referral of walk-in patients (self-referral) from emergency room or outpatient departments of hospitals. Criteria and method of referral vary widely, as does the amount of training professionals receive on conditions to be referred. Public hospitals, and hospitals with trained child abuse teams, appear to make many more internal referrals than do private hospitals and physicians, and to receive more referrals from public agencies and other medical personnel.	When police have reason to believe a child's life or safety is in imminent danger or that the injuries are severe, they may respond, using emergency family crisis intervention techniques, and possibly transporting the child directly to the hospital for examination and treatment. If an ICEU, after home examination of a child, determines that there is sufficient injury to warrant examination in the Child Injury Medical Center, they either obtain consent from the parents, or contact police to obtain a body warrant, for removal to the CIMC. In some instances, children will be referred to the CIMC by private physicians; by other hospitals; or by the emergency room, outpatient department, or other units of the designated CIMC hospital. Self-referral by parents of injured children may also occur.
3.4 *Medical Diagnosis and Decisions*	Common elements of a diagnostic workup in cases of suspected abuse include a radiologic bone survey (full-body X-ray), and observation of any tissue trauma (bruises, swelling, cuts, burns). The major decisions include whether the injury was likely to have been inflicted; whether the child should remain in the hospital for treatment or for protection from re-injury; and whether the case should be referred for treatment or court processing.	The key decision to be made by the CIMC is whether or not, from medical evidence, it appears that the child's injury(s) occurred in a non-accidental manner, or that the accidental nature of the injuries appears seriously questionable. In either instance, the child may be in jeopardy of reinjury, and the legal questions of the child's protection, custody, and possible placement are at issue. Such cases are referred to the county/city attorney for a legal determination of whether a petition is warranted.

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
3.4 (Cont'd.)		The CIMC examination process would include obtaining a medical history from the parents, performing all indicated diagnostic tests and procedures (possibly including a blood survey, examination for tissue trauma, and a radiological bone survey), and a case conference by medical team members to discuss findings.
4.0 *Psychiatric/ Psychological Examination*		
4.1 Child	The child may or may not receive a psychological evaluation, depending upon the resources at the disposal of the medical facility or social agency involved in the case.	Psychiatric or psychological examination of the child will not be a routine part of the initial CIMC examination. Whenever psychiatric or psychological testing of the child is desired, such testing shall occur only: (1) after consent from the parents or the child's guardian ad litem is obtained (i.e., where parental/caretaker consent is not given) and upon court order after a hearing.
4.2 *Parents*	Parents may or may not receive a psychiatric of psychological evaluation, depending upon the resources at the disposal of the court, the medical facility or social agency involved in the case. Since parents are the focus of concern and treatment in verified cases of abuse, psychiatric/psychological evaluation usually occurs during treatment. The most common form of services offered to parents who may abuse their children is social casework, which includes some form of psychological or quasi-psychological evaluation.	Psychiatric or psychological examination of the parents will not be a routine part of the initial CIMC examination. Whenever such testing is desired, it shall occur only: (1) after consent from the parents is obtained; (2) where consent is not given, upon court order after a hearing.
5.0 *Access to Information in Other Agencies*	Access to information in community agencies, including police records, mental health agency records, public welfare and protective service agency records, private social agency records, health (hospital and physician) records, and school records is only minimally constrained by agency policies. Access may be virtually unlimited through either formal or informal information-sharing arrangements.	At the stage of initial response to a suspected child abuse case, both the police and the ICEU will have access to their own records indicating previous contacts with families. Hospitals similarly will have access to their internal records to determine previous contacts with a particular family or individual; they may further have informal arrangements with other hospitals concerning confirmation of previous contacts. The ICEU, the police, and the CIMC may obtain information concerning legally confirmed instances of child abuse from the court-centered Child Abuse Information File (CAIF) to the extent of determining whether there has been a confirmed instance of abuse in a given family. Records from other community agencies and other sources (protective services agencies, schools, mental health agencies) will not be consulted during the process of examination of the injured child. The police, ICEU, and CIMC are informed of the outcome of suspected abuse cases for inclusion in

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
5.0 (Cont'd.)		their records. If a case is adjudicated, the police, ICEU, and CIMC Have access to the CAIF regarding the case in the event that the same child or a sibling appears as a suspected abuse case.
6.0 *Legal Rights During Examination Process*		
6.1 *Parents*	Usually, except for a private physician visiting a patient, or a public health nurse making a home visit, there is no medical examination in the home. The parents have no legal rights with respect to examination and treatment of their child in a hospital if the child is under a police hold or in the protective custody of the hospital.	*Due Process: Home Examination and Removal* Parents can be compelled to allow initial examination of their child only through presentation by the ICEU of a warrant. They can be compelled to allow the child to be removed to the CIMC only upon presentation of a body warrant. Police officers may examine and remove a child in an emergency situation if they have probable cause to believe that the child's life or safety is in imminent danger. Otherwise, the ICEU must be contacted, and the same due process requirements of obtaining warrants applies. *Notice, Right to Remain Silent* In every case entering the CIMC where child abuse is suspected or diagnosed, the parent is immediately informed of the law; the CIMC procedures, including authority to hold the child for 24 hours; and the possibility of subsequent legal action. Parents are informed that discussions with CIMC personnel may be used in court process, and that they have a right to remain silent. Parents are advised of their right to appointed counsel in the event of any court hearing. *Due Process: Emergency Custody and Appointed Counsel* If the CIMC or other public institution wishes to retain custody of the chiild without parental consent, a Temporary Protective Custody Hearing (and subsequently an Interim Custody Hearing) must be held. At the first such hearing, counsel for the paretns is appointed and compensated by the public, unless the parents can afford to retain private counsel. *Due Process: Hearing and Burden of Proof* Parents are entitled to a legal determination of whether their child is at risk due to suffering a non-accidental injury. The burden of proof is on the state, and there is at every stage of the examination and legal process a presumption of fit parenting. Accordingly, parents are entitled to the least intrusive public intervention necessary at each stage of the process, including ICEU and CIMC examination; both in terms of information collected and legal coercion employed.

E. EXAMINATION OF THE INJURED CHILD—Continued

	Present System	*Proposed System*
6.2 *Child*	Legal rights of the child during examination are seldom specified in operating child abuse systems. In some jurisdictions, the child is assigned legal counsel or a guardian ad litem during civil court proceedings, including temporary protective custody hearings.	The child also is entitled to the least intrusive public intervention necessary to ensure any needed medical treatment and to determine whether the child is at risk in the home environment. The interests of the child in the examination process should be represented by a guardian ad litem who is a continuing participant in the multi-disciplinary team process. At the first point that the issue of custody is raised in court (e.g., TPRO), the child obtains council.
7.0 *Multi-Disciplinary Team*	Some hospitals in metropolitan areas, particularly university affiliated teaching hospitals, have formed multi-disciplinary teams for the detection and handling of suspected child abuse. These teams may be comprised of some or all of the following staff of consultants: pediatrician, nurse, medical social worker, psychiatrist, psychologist and an administrative psychologist, and an administrative coordinator. These teams have specific protocols for handling abuse cases which define diagnostic and evidence gathering procedures for possible court process. Case conferences concerning suspected abuse cases generally include staff from outside agencies who are involved in the case and regular staff from these agencies, such as: public welfare/protective service worker, policeman, probation officer, private social service agency worker, mental health agency worker, district attorney, and city/county attorney. Decisions made by such teams include whether to ask for protective custody of a child, whether to file a neglect or dependency petition, whether to recommend termination of parental rights, and treatment plans for parents to be recommend to courts.	The CIMC will be comprised of those medical professionals and clerical support necessary to complete a medical diagnosis of the condition of a child and to determine the likelihood that an injury was sustained non-accidentally. It is anticipated that the CIMC team will include a pediatrician, a pediatric nurse, a clerk, and will have access to such diagnostic support staff as radiologists, laboratory technicians, psychiatric staff, and other regular medical staff of the designated hospital. Representatives of other community agencies will not be included on the CIMC team, nor will a medical social worker participate in the initial CIMC decision-making process. The full trauma team that would have a role in the post-petition investigation process and at the dispositional stages would include an appropriate complement of non-medical personnel, e.g., medical social workers.

F. PROTECTIVE CUSTODY

	Present System	*Proposed System*
1.0 *Removal Criteria*	Removal of a child from his/her own home must be either: • Voluntary (i.e., with parental consent) • By court order, or • Necessary to ensure a child's life, health, or safety. 'Emergency' removal must be based on: • The parent's condition • The child's condition (e.g., medical necessity) • The absence of any parent or other caretaker of a young child	A law enforcement officer, physician or ICEU examiner has reasonable cause to believe that the child requires medical treatment and examination as a result of a suspicious injury and the parents or guardian refuse to consent to the child's transportation to an appropriate medical facility for treatment and examination. The parent, guardian or legal custodian has substantially or repeatedly abused (or neglected) the child and the child's safety or well-being is endangered or the parent lacks the capacity for any reason to protect the child in the immediate future or for an indeterminate period, with or without the provision of appropriate treatment or services. The child's life or safety is jeopardized by the likelihood of serious inflicted injury, with or without the provision of appropriate treatment or services to the parent, guardian, or legal custodian.
2.0 *Removal Procedures*	When parents are not available (i.e., the child has been 'abandoned'), efforts should be made to locate them or some other responsible adult (e.g., a relative) who will assume temporary care of the child. If no responsible party is able and willing to care for the child, arrangements should be made with an appropriate temporary placement facility to which the child will be taken. If action has been initiated by a social worker and is not voluntary, law enforcement should be contacted to execute the removal.	*Emergency Removal* When the parent or guardian is absent or objects to removal, and there is suspected abuse or an imminent danger to the child's life or health or the child requires immediate medical treatment and examination, a physician, police officer, the head of a hospital or other medical facility or an ICEU worker, without consent of the child's parent or guardian, may take or retain a child in temporary protective custody, must immediately notify the parent or guardian of the child, promptly initiate proceedings in court for continued temporary custody of the child within a hospital or other medical facility, and a shelter care hearing must commence within 48 hours to determine whether continued custody is warranted, pending possible adjudication. *Voluntary Protective Custody* When the parent is agreeable to removal, the consenting parent, in consultation with legal counsel, should jointly submit a petition to the court filed by a child welfare agency. The petition should be reviewed by a guardian ad litem for the minor and counsel for the minor, unless the guardian ad litem is an attorney. At the hearing held on the petition, the judge should ensure that: • All possible efforts have been made by the child welfare agency to effect an improvement of the home situation to ameliorate those factors leading to the decision for voluntary placement. • Counsel for the parents and the minor have reviewed the nature of the child welfare agency's activities during the investigation and removal process and are satisfied that the process had been conducted without duress or coercion.

F. PROTECTIVE CUSTODY—Continued

	Present System	*Proposed System*
2.0 (Cont'd.)		• The decision by the parent(s) was made without coercion. • The parent(s) understand the nature and consequences of the decision. • The agency had an acceptable plan for treatment of or services to the family unit aimed at restoring the parent-child relationship. • The parents or legal guardians had consented to working with the treatment or service plan that would enable them to resume responsibility. • The parents or legal guardians had consented to working with the treatment or service plan that would enable them to resume responsibility for the child.
3.0 *Use of Detention*	As a general rule, states may house abused/neglected children in detention facilities depending on: • The time of day (e.g., after 5 p.m.) • Non-availability of other placement resources • The agency initiating removal In 'emergency' situations (see 1.0-C, subsections a. and c.), police will most often remove to detention. In states where a social service agency is the mandated report recipient, and the situation is not an 'emergency,' detention most probably will not be used.	Under no circumstances will detention facilities be used to house children in suspected abuse cases. Custody of children may be assumed by the CIMC (see E. 2.0 above), or may be placed in another appropriate setting (relatives, foster home, group home) by the court.
4.0 *Use of Hospital*	Children are retained in, rather than removed to, a hospital except in an emergency situation. Eight states (Connecticut, Kentucky, Massachusetts, Michigan, New Jersey, New York, North Carolina, and Tennessee) specifically authorize medical personnel to hold abused children against parental wishes for a specified period of time or until a court hearing on the matter may be held. Two states, Michigan and Tennessee, require that the child be undergoing treatment. These provisos allow a physician or hospital to hold a child, with or without medical necessity, if, in the doctor's judgement, the child would be in danger of further injury should he/she be released. A special clause found in the reporting laws of 16 states and D.C. provides that a child is not abused/neglected solely because of his parents' religious beliefs if he/she is receiving treatment from a legitimate faith healer, Christian Science practitioner, etc. In these cases, a court order is necessary to secure medical treatment.	The hospital plays a protective custody role only insofar as the CIMC may assume custody of a child (after appropriate court hearings) during the medical examination and treatment process. Extended use of hospital facilities for protection of a child is avoided as an inappropriate and inefficient use of costly resources.

F. PROTECTIVE CUSTODY—Continued

	Present System	*Proposed System*
5.0 *Emergency Services*	Child Welfare League Standards for Protective Service provide for a 24-hour evaluative service to be staffed by experienced social workers and states that, insofar as possible, emergency (unplanned) removal of a child from its home should be avoided. With the rare exception of emergency consultation provided by some hospital "Trauma Teams," few services are provided on an emergency basis. Examples of exceptions to this dearth of emergency services are the crisis nursery, currently in use in Denver and Adams County, Colorado; the Emergency Parent Program in Buffalo, New York; and the Comprehensive Emergency Services (CES) program in Nashville, Tennessee. CES has several components including 24-hour emergency intake; emergency caretakers, parents, and homemakers; emergency foster homes; shelter for families and for adolescents; and neighborhood crisis centers.	Emergency evaluation of child injuries, by ICEU, and treatment and diagnosis by CIMCs at any hour are central elements of the proposed system. The ICEU team will be prepared to provide referrals to existing community services and resources on an emergency basis. Such referral will be voluntary; the family will not be reported to the agency. It is recognized that in a majority of communities there are not adequate emergency services available, and development of Comprehensive Emergency Service programs (including crisis day care, homemakers, shelter care, and counseling) is recommended. Protective Service units of public welfare agencies also may be called upon to provide emergency service at the intake stage.
6.0 *Use of Foster Care*	Foster Care is used for protective custody when: • The existing situation is an emergency, and • No other resources are available that would allow the family to receive services and maintain the child in the home, and • Temporary foster homes are available, and • Either the removal action has been initiated by a protective service worker or the law enforcement agency serving as report recipient in a given state is mandated to refer the report to a social service agency.	Foster care will be one dispositional alternative in court processes. Since only medical emergencies will be brought into the proposed system, emergency foster care will not be utilized; all cases of emergency removal will be referred to the CIMC. Foster care will be regarded as a less desirable disposition than plans which would allow the child to remain in the home. The dual objectives of the proposed system are: (1) to protect the health and safety of the child; and (2) to provide the least disruptive intervention necessary to achieve this protection.
7.0 *Court Hearing*	In all states a court review of the removal decision is necessary for any agency to retain a child in protective custody beyond a specified period of time (e.g., 48 hours). In all states a temporary court order for protective custody may be obtained within minutes by telephone in an emergency. In the eight states (see 4.0) where hospitals have a right to retain a child at their own discretion, this decision is subject to court review on the next court day. Parents in all states must attend the custody hearing and notice must be given between the time the child is removed	Authorization for protective custody occurs in either the Interim Custody Hearing or the dispositional hearing of the civil adjudication process.

F. PROTECTIVE CUSTODY—Continued

	Present System	*Proposed System*
7.0 (Cont'd.)	from the home and the next court (working) day.	
7.1 *Notice*	Although all states require court review of protective custody (a removal of child's custody from the parents) at some point in time, ranging from 24 hours to several days, the parents are not necessarily informed of this hearing, which may be an *ex parte* proceeding with only petitioning counsel present. In some cases, a temporary court order for protective custody may be obtained by telephone. Provisions for notice of court hearing vary from state to state.	Parents are provided notice of abuse proceedings by the CIMC, at the point that the suspicion of child abuse occurs.
7.2 *Time Elapsed*	In the states which allow emergency removal of children or holding of children by hospitals and physicians without prior court authorization, court hearing occurs at varying times after removal, although the first regular court day is a common standard. Time elapsing before court review of temporary protective custody varies widely from state to state.	The first court hearing concerning custody may take place at the following points: • Within 24 hours of CIMC intake, if parents refuse to consent to a second period of 48 hours of treatment.* • Within 48 hours of CIMC intake, if parents consent to initial treatment, but refuse to consent to a second period of 48 hours of diagnosis or treatment. • Within 96 hours if parents consent at both points, and the hospital wishes to retain custody for further treatment or diagnosis; or the case has been referred for petition and petition has been filed; *or a pre-petition investigation has* been initiated. *(Temporary Protective Custody Hearing)
7.3 *Legal Representation*	Rights of parents to legal counsel (privately retained or publicly appointed and funded) varies from state to state and within states. Parents themselves may not be present at initial court review of emergency protective custody, and more frequently they are not represented by counsel. The child also may or may not have separate legal representation.	Parents are informed of their right to counsel (and to remain silent) at the point at which the CIMC begins entertaining serious suspicions that injury may have been inflicted and the case may be referred for petition. They may retain private counsel at that time. Parents who cannot afford counsel are provided a court-appointed and publicly funded attorney at the first court hearing in the case. Parents are appointed counsel, and the child is appointed both counsel and a guardian ad litem, at the first instance of court action. This is either at the TPRO hearing (if parents do not consent to hospitalization) or at the ICO/TICO hearing. Counsel is present at all custody hearings.
8.0 *Limits on Duration of Protective Custody*	Pursuant to court order, protective custody can continue for the duration of the pending proceedings, however long that may be (see 7.0)	Protective Custody is subject to the following limitations:

Event	*Time Elapsed*	*Duration*	*Protective Custody Order*
Entry into CIMC	0 days	2 days-	Initial TPRP or Consent
Retention in CIMC	2 days	2 days-	Second TPRO or Consent
Pre-Peition Investigation	4 days	3 days-	Temporary Interim Cust. Order
Petition	10 days	10 days-	Terim Custody Order
Adjudication-Continuance	17 days	10 days-	Interim Custody Order (2)

F. PROTECTIVE CUSTODY—Continued

	Present System	Proposed System
8.0 (Cont'd.)		Time Elapsed / Duration / Protective Custody Order Adjudication 27 days 10 days- Interim Custody Order (3) Disposition-Continuance 37 days 10 days- Interim Custody Order (4) Disposition 47 days 47 days In the absence of consent, a Temporary Protective Restraining Order (TPRO) may be granted by the court, after a hearing at which parents and counsel for all parties are present. A second TPRO may be granted, again after a hearing, for an additional 48 hours.
9.0 *Measures to Encourage Contact Between Parent and Child*	In the present system, in all states, no statutory measures exist to encourage parent-child contact during the protective custody period.	Provision for maintaing contact between the natural parents and the child will be a necessary part of every custody arrangement (except possibly the final disposition, if it is termination of parental rights). In the most extreme circumstances when the parents are judged to be actively dangerous and hostile to the child, contact may occur under strict supervision, or may be temporarily curtailed. Provisions to maintain contact may include regular and frequent visitation, short-term return of the child to the home (e.g., overnight or for an afternoon), participation of both parents and child in a family therapy clinic or shelter, or return of the child to the home, with home-centered therapy or supportive services.

B. Civil Adjudication or Alleged Child Abuse Cases

The process of civil adjudication of child abuse can be broken into five separate components, each involving its own set of laws, rules, and procedures. In addition, the civil adjudication process as a whole involves a set of laws, rules, and procedures which apply generally to each component of the process.

First there is the overall framework for the adjudication process which consists of explicit and implicit conceptions of the purposes of and basis for court processing, the nature of that process, and the substantive and procedural due process rights of parents and children which ultimately reflect how the philosophical concepts are translated into practice and determine the degree of fairness of the process.

Second, there is the petition process and the legal and procedural prescriptions which determine who may initiate court proceedings, by what means, and in what forum (or court).

Third, there is the pre-trial process and the laws and agency procedures which determine who may conduct investigations, what the scope of the investigation may be, who has access to the reports and findings of the investigation, and how these may be used.

Fourth, there is the trial or adjudication process and the laws and rules which govern the conduct of the trial, the admissability of evidence, and the burden of proof.

Fifth, there is the disposition process and the legal and agency procedures and practices pertaining to the investigation for and selection and imposition of the disposition, the custody and placement of the child, and the services and treatment provided to the child and the parent.

In the Charts G and H that follow, we have attempted to summarize the key elements of the present civil adjudication process in the areas outlined above and to compare them with the proposed provisions of the model system.

In Chapter IX, we present a chart of the decision-making functions of the model system's adjudication process, Model System Chart III covering Phase III: Adjudication Process. Model System Chart III specifies the decisions to be made in each phase of that process, the appropriate decision-maker, and the criteria/guidelines for making the decision. The sequences of decisions in this chart and the options available at each decision point are graphically presented in Flow Chart II: Child Abuse - Petition to Disposition.

Outline of Charts G and H: Comparison of the Key Provisions of the Present and Proposed Systems of Handling Child Abuse

G. Court Petition

1.0 Purpose
2.0 Who May File
3.0 Forms and Content of the Petition
4.0 Legal Sufficiency Standards
5.0 Court of Jurisdiction

H. Civil Adjudication Process

1.0 Prehearing Investigation
2.0 Due Process Standards
3.0 Legal Representation
4.0 Dispositional Alternatives
5.0 Monitoring of Court Actions

G. COURT PETITION

	Present System	*Proposed System*
1.0 *Purpose*	The purpose of filing a petition is to enforce the statutory purpose of laws governing child abuse. (See Section A, 1.0). More specifically, a petition is filed when the agency responsible determines that court intervention is needed to insure protection of the child, or in the aftermath of an emergency temporary removal of a child from the home, or to coerce parents to accept services, or to insure services will be provided.	The purpose of filing a petition is to accomplish the stated purposes of the proposed system for handling child abuse. (See Section A, 1.0). In addition, the purposes are to insure that *at the earliest possible point* after suspicion of child abuse arises, the parent(s) suspected of abusing the child(ren) are afforded full due process rights and a legal forum within which the issue of abuse can be determined; and that any interventions by agencies in the life of the family, on behalf of children or to provide services, are by court order and subject to court review, all under due process.
2.0 *Who May File?*	The party filing the petition may be one of several including the locality's corporation council, or the welfare, social service or protective service agencies, or a hospital, or the probation or court intake officer and possibly a private individual. Who among these various parties actually files depends on who received the initial report or who conducted the initial investigation after the report was received.	The party filing the petition and responsible for its contents is the county or city attorney of the locality where the alleged incident of abuse occurred.
3.0 *Forms and Content of the Petition*	Typically, the petition will state the child's name, residence, often its age, the names of the parents or other custodians, their residence, and the facts alleging an incident of abuse. The latter may often be a bare allegation that the child is abused (or neglected or dependent depending on whether abuse is a sub-category of these latter classifications). The petition may have attached to it a motion for temporary custody pending the proceedings if the child has not already been removed from the home. The petition is usually captioned, "In Re ———— a minor child."	The petition will state the child's name, its age, the names and addresses of the parents and/or other caretakers, their residence, whether the child is in custody and where, whether a TPRO has been issued and when, and a specific statement of the facts—medical and otherwise—which support the allegation that the child's injury or condition was non-accidentally caused and constitutes abuse. The petition will be entitled, "In Re (the parent(s) (and/or caretaker) of a minor child(ren)."
4.0 *Legal Sufficiency Standards*	The petition must give sufficient notice of the nature of the charge and the grounds must comport to those contained in the applicable statute. Usually both are satisfied merely by repeating the language of the statute in the petition.	The county/city attorney will screen all referrals and will not file a petition unless (1) there is sufficient evidence, which if unrebutted would establish the facts alleged, and (2) the facts alleged if uncontroverted will support a finding that the child was abused.
5.0 *Court of Jurisdiction*	The court of jurisdiction is usually whichever court or section of a court in the state or locality that exercises jurisdiction over juveniles as the juvenile court. The hearings in such court may be held initially before a referee rather than a judge.	The court of jurisdiction is the Family Court which is a division of the highest court of general trial jurisdiction and which exercises exclusive original jurisdiction over all matters pertaining to children and families. All hearings in such court will be before a judge.

H. CIVIL ADJUDICATION PROCESS

	Present System	*Proposed System*
1.0 *Prehearing Investigation*	Upon filing of petition, the court may order an investigation. This may be conducted by court personnel (probation) or the court may assign another agency (e.g. protective services); or where parental resistance is expected, the police. This investigation is either discretionary or compulsory. It's purposes are to serve as a judicial fact-finding measure and to develop information for the disposition. (see Chart D for scope and procedure.)	Upon filing of a petition, the investigative staff of the county/city attorney will conduct any further investigation needed (investigation: mandatory, scope: discretionary). The purpose of the investigation will be to gather evidence necessary for the adjudication hearing. (See Chart D for elaboration of investigation procedures.) Investigation to be completed and hearing to be commenced within 10 days of filing of petition. (One 10 day continuance is allowed.)
2.0 *Due Process Standards*	Notice and service of summons is required. Some form of hearing is held. Generally it is informal, closed to the general public, and with no provision for jury trial (in 36 states). The parties are allowed to cross-examine and present witnesses. The burden of proof required is usually some formula based on the preponderance of the evidence. The privilege against self-incrimination will obtain whenever criminal prosecution could result. The presence of the child at the hearing can be waived. A record of the proceedings will be kept. There is a right to appeal but no provision for appointed counsel on appeal.	Notice and service of summons is required. The hearing will be informal, closed to the general public, tried before the court without a jury. The parties will be allowed to cross-examine and present witnesses. The burden of proof will be based on the preponderance of the evidence. The privilege against self-incrimination will be extended to the parent/caretaker whether or not criminal prosecution is possible. The child and/or a guardian ad litem shall be present at all proceedings. A verbatim transcript shall be kept. All parties have a right to appeal, to appointed counsel, and to a copy of the transcript. All information will be shared in advance of hearing as per rules of discovery in civil proceedings.
3.0 *Legal Representation*	Usually the parties (parent and child) will have a right to counsel (36 states). Indigent parents may also have a right to *appointed* counsel, but the child may not (in 25 states). The child will usually be considered to be represented by the state or agency attorney representing the petitioner. The child will not have a guardian ad litem appointed. In general there is no provision for *appointed* counsel on appeal.	All parties including the child are represented by counsel. All will have a right to appointed counsel. The county/city attorney will represent the state as petitioner in all proceedings. A guardian ad litem (as well as counsel) shall also be appointed for the child to assist counsel and act on behalf of child.
4.0 *Dispositional Alternatives*	The range of specific dispositional alternatives will vary greatly. These can be grouped into several categories: Dismissal; Temporary Orders; Protective Supervision; Transfer of Legal Custody; and Termination of Parental Rights. The most common specific dispositions involve transfer of custody to a public agency or institution or a private agency (e.g. foster care) or to a relative. There is unlikely to be any order requiring the parents to obtain specific counseling or treatment and where there is such order, the services are likely to be few and the follow-up sporadic.	Disposition will be made subsequent to a hearing separate from the adjudication. Disposition hearing and order will be held within (10) days following adjudication. A separate dispositional study will be conducted by a protective services agency, probation or specialized probation unit. This study can be commenced before adjudication but findings will not be presented to a judge until after adjudication. This study can include psychological/psychiatric testing of parents, social history, evaluation of environment and risk to child, etc.
	Disposition is usually designated as a separate proceeding but can be held immediately after adjudication. An informal adjustment may be arranged but under the present system such informal adjustments usually occur prior to filing.	The selection of the appropriate disposition will be based on these criteria.

H. CIVIL ADJUDICATION PROCESS—Continued

	Present System	*Proposed System*
5.0 *Monitoring of Court Actions*	The only monitoring of court actions is through the appeals process. There is a right to appeal but no right to appointed counsel on appeal. Thus appellate review is negligible. Court orders are subject to modification, but review is infrequent.	All orders of adjudication and disposition will be subject to appellate review. Both parent and child have right to appeal, appointed counsel, and free transcript on appeal.

CHAPTER IX. MODEL SYSTEM DECISION-MAKING GUIDE

A major theme of the Prescriptive Package is that any system or non-system for handling child abuse consists of a determinate number and type of key formal decisions and an indeterminate number of lesser informal decisions that cumulatively may well outweigh the ultimate importance of the formal decisions. These formal and informal decisions are simply answers to questions that are both explicit and implicit in the decision-making process for handling child abuse. By making explicit the key questions that justice system officials have to answer and keying the answers to the types of decisions that should be made in accordance with the policies and practices proposed in the model system, we hope to provide a valuable training and educational tool, which also can be adopted to answers that may be more relevant to current general practices in handling child abuse.

The following series of charts: Model System Chart I — *Phase I: Identification to CIMC Intake;* Model System Chart II — *Phase II: CIMC* Intake to Petition; and Model System Chart III — *Phase III: Civil Adjudication Process* specify the key decisions to be made, the appropriate decision-maker, and the criteria/guidelines for making the decision. The sequence of decisions in these charts and the options available at each decision point are graphically presented in Flow Chart I: *Child Abuse - Identification to Petition* for Model System Charts I and II; and in Flow Chart II: *Child Abuse - Petition to Disposition* for Model System Chart III.

Model System Chart I

Phase I: Identification to CIMC Intake

Decision	*Decision-Maker*	*Criter[illegible] Guidelines*
1.1 Contact ICEU Intake Process (hot line)	Any Source: Professionals; Schools; Neighbors; Relatives; Protective Services; Police	See Part II, Chapter IV, B; Injuries Qualifying as Potential Abuse
2.1 Emergency Referral to CIMC or other hospital	2.2 a) Police b) Protective Services c) ICEU (See 4.3)	2.3 a) Police: (i) Determination (medical) of immediate need for treatment. (ii) Referral to CIMC whenever possible without risk to child; no questioning to occur. (iii) Parents to be informed of place and allowed to accompany. b) Protective Services: same as 2.3(a)(i)-(iii).
3.1 ICEU contacts parents; visits family	3.2 *ICEU*	3.3 a) All reports are followed up. b) Initial contact by telephone if possible. c) Parental consent to be obtained for visit. d) Visit to be made within 2 hours by ICEU.
4.1 Determination (in the field) that child needs medical care and/or examination: Referral to CIMC	4.2 a) Police (see Emergency Referral) b) Protective Services (see Emergency Referral) c) ICEU	4.3c.) ICEU (i) Visits home; examines child subsequent to each report (ii) Determination of need for referral based on: (See Part II, Chapter IV, A.) (iii) Removal to CIMC only; notice to parents of place of removal. (iv) Consent for removal of child to CIMC to be obtained from parents. (v) Emergency removal without consent or body warrant based on: a) Determination (medical) of immediacy of need for treatment of injury. Parents to be informed of place child is taken to. (vi) Removal without consent, non-medical emergency (see 5.3)
5.1 Obtaining Warrants a) For ICEU-house visit	5.2 a) ICEU only—Court or Magistrate issues warrants	5.3 a) House visit (i) Warrant to be obtained where *consent* (see 3.3) is not given. (ii) ICEU must show probable cause (information and belief based on report from an informant is sufficient). (iii) Scope of warrant limited to entry of home for purposes of examination of (specified) child(ren) to determine if there is an injured child.

Model System Chart I
Phase I: Identification to CIMC Intake—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
5.1 (Cont'd.) b) For removal of child (see also Emergency Referral 2.1)	5.2 (Cont'd.) b) ICEU only—Court or Magistrate issues warrants	5.3 (Cont'd.) b) Removal of Child (i) Body warrant to be obtained where *consent* (see 4.3) not given. (ii) Exception to warrant: *medical emergency* (see 4.3) (iii) Warrant to be issued upon showing of probable cause of *need for removal* (see 4.3) (iv) Removal to CIMC only; notice to parents of place of removal.
c) Search (investigatory) prior to filing of petition	c) Police—Court or Magistrate issues warrants	c) Search prior to petition (i) Warrant to be obtained where consent is not given. (ii) Notice of rights, accusatory nature of search, and possible adverse consequences to be given prior to seeking consent to search and prior to execution of search warrant. (iii) Warrant to be issued upon showing of probable cause that:: a) Non-accidental injury to child occurred. b) Specified evidence tending to show nature and cause of injury is likely to be found. (iv) Warrant to specify place(s) to be searched and objects(s) of search. (v) Exceptions to warrant: (per statutory and constitutional law) a) Child fatality and probable cause to believe that: - death was the result of a homicide, and - evidence will be lost or destroyed if not seized immediately. or b) "Plain-view" exception to 4th Amendment. or c) Search is made incident to a lawful arrest (for homicide*) or d) Search is made for self-protective purposes (probable cause to believe there is a weapon which could be used to injure police officer). e) Notice of rights to be given concurrent with any search without a warrant.
6.1 Autopsy/Coroner's Inquest	6.2 D.A. Police Hospital/M.D. certifying death	6.3 1. To be performed whenever death of child occurs and: a) Cause of injury resulting in death not known; or b) Cause of death not known; or c) Non-accidental nature of fatal injury suspected. 2. Standard autopsy procedures to be followed (e.g. photos, toxicology and tissue exams, etc.) 3. Law enforcement officer should be present.

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*Under model system, homicide may be the only form of child abuse subject to criminal prosecution.

Model System Chart I
Phase I: Identification to CIMC Intake—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
7.1 Referral to CIMC by other emergency room or outpatient clinic	7.2 Supervising M.D. of emergency room or outpatient clinic	7.3 1. The supervising M.D. of any hospital emergency room or any outpatient clinic which does not have the capability of conducting the examination/evaluation process of the authorized CIMC shall refer any injured child case to the CIMC whenever the injury to child appears to be non-accidental or whenever the accidental nature of the injury cannot be definitively ascertained. 2. Such referral shall occur, and the physical transporting of the child to the CIMC by the emergency or outpatient clinic shall occur as soon as the child's condition permits. 3. Any discharge of a child in such cases shall be effectuated by the CIMC, after a referral has occurred.
8.1 Referral to CIMC by private physician	8.2 Private physician	8.3 1. A private physician has a duty to refer any injured child case to the CIMC whenever the injury to the child appears to be non-accidental or whenever the accidental nature of the injury cannot be definitively ascertained. 2. Such referral shall occur as soon as the child's condition permits and shall be made whether or not the injury requires hospitalization. 3. Transportation of the child to the CIMC shall be arranged between the physician and the CIMC. 4. The physician shall inform the parents of the place to which the child is referred; his duty to make the referral; and reasons therefore.

Model System Chart II

Phase II: CIMC Intake to Petition

Decision	*Decision-Maker*	*Criteria/Guidelines*
1.1 Admission of Child to CIMC	1.2 CIMC admissions personnel	1.3 All injured children referred to a CIMC from whatever source shall be admitted to the hospital initially for the limited purpose of conducting an examination of the child to assess the child's medical condition, to prescribe the nature and scope of any medical care and treatment that the child's condition may require, and to provide any such care and treatment that is immediately required.
2.1 Initial questioning of parents as to place and circumstances of injury	2.2 CIMC admissions personnel and examining physician	2.3 In conducting such examination: a) the child's parents may be questioned concerning the child's medical history, or b) may be questioned generally concerning: (i) the place where the child's condition developed or injury occurred, and (ii) any other facts or circumstances concerning the occurrence of the condition or injury in accordance with the usual information obtained in hospital admissions procedures. c) The questioning permitted in 2.3(b) shall be general, non-accusatory, and non-interrogatory. d) Any questioning (i-ii) shall be conducted only by the examining physician. e) Any information obtained at this point other than the child's medical history shall be inadmissible as evidence in any subsequent legal proceeding.
3.1 Preliminary screening for possibility of abuse. Discharge or initiation of other legal action.	3.2 CIMC diagnostician or diagnostic team	3.3 a) Once the child's immediate medical condition is assessed and any immediate medical care is prescribed and being provided as necessary, a diagnostician or diagnostic team designated by the CIMC shall evaluate the child's condition, whether or not such condition requires hospitalization or other hospital-provided medical care or treatment, to determine whether such condition might qualify as potential child abuse (see Definitions: child abuse). The final determination of whether such condition might qualify as child abuse should be the responsibility of a pediatrician. If such condition should not qualify as potential child abuse (e.g. neglect, failure to thrive sexual abuse, medical care neglect, drug abuse, etc.) the child shall be treated as necessary and discharged from the hospital or, as appropriate, processed in accordance with neglect laws or other applicable laws. b) A determination of possible abuse shall be made in accordance with the criteria for identifying possible non-accidentally caused injuries.
4.1 Questioning parents as to place and circumstance of injury suspected as abuse.	4.2 CIMC diagnostic team physician or physican on the ward	4.3 Where such condition or injury might constitute child abuse a member of the diagnostic team shall: a) Question the parents about the facts concerning the child's condition or injury: (i) this questioning shall be performed by a diagnostic

Model System Chart II

Phase II: CIMC Intake to Petition—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
4.1 (Cont'd.)	4.2 (Cont'd.)	4.3 (Cont'd.) team physician or the examining physician on the ward; (ii) the purpose of such questioning is to establish the parent's account, in *minimum* detail of where and how the injury occurred or the condition developed; (iii) before such questioning occurs, the parents shall be informed by the examining physician that: a) the information may be used in a subsequent legal process if it is determined that "someone injured the child"; b) s/he has a right to not answer the questions and to have an attorney present before answering; c) if the parent does not answer the questions, this will not be held against him/her; and d) that the hospital may conduct medical tests to determine the cause of the condition or injury and may apply for a court order to hold the child for such tests if the parents do not consent to the child's hospitalization. b) If questioning occurs, obtain information as to: (i) the place where the injury occurred or the condition developed, and (ii) the sequence of events leading to and following the occurrence of the injury or the development of the condition. This information shall be asked for once without pressing details, the answers shall be recorded and the information read back for verification and an acknowledgement shall be signed by the person giving the information.
5.1 Examination and testing as to extent and cause of injury: type of diagnostic procedures required and length of hospitalization.	5.2 CIMC diagnostician or diagnostic team	5.3 Whenever the child's condition or injury might qualify as child abuse, and: a) the injury or condition appears to be non-accidental; or b) the accidental nature of the injury cannot yet be definitively determined and the parents offer no explanation; or c) the explanation given by the parents does not comport with what the medical examination already has revealed about the injury or condition; or d) the parents explanation cannot yet be medically verified, the diagnostic team shall e) determine what medical, X-ray, and laboratory tests are appropriate to determining the nature of the injury or condition and how much time is necessary to complete such procedures.
5.11 Need for continued hospitalization	5.21 CIMC diagnostician or diagnostic team	5.31 f) determine whether the child requires hospitalization for medical treatment for his injury or condition; and g) inform the parents of this fact and also inform them that additional tests will be conducted to determine the nature of the injury or condition; or if the child does not require hospitalization for care and treatment.

Model System Chart II

Phase II: CIMC Intake to Petition—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
5.11 (Cont'd.)	5.21 (Cont'd.)	5.31 (Cont'd.) h) inform the parents that it wishes to h[illegible]ze the child for further examination and observatio[illegible]termine the accidental or non-accidental nature of the child's injury or condition.
6.1 Obtaining a temporary protective restraining order: parents consent to hospitalization	6.2 CIMC diagnostic team; parents	6.3 Under either 5(f) or 5(h), the diagnostic team must inform the parents of the expected duration of the hospitalization for examination, observation and testing; and the parents must consent to hospitalization or a temporary protective restraining order (TPRO) must be obtained before the child may be retained as an in-patient of the hospital.
6.11 Obtaining a temporary protective restraining order: parents do not consent to hospitalization	6.21 CIMC diagnostic team; court/magistrate (*parents do not consent*)	6.31 If the parents do not consent, the diagnostic team shall apply immediately to the appropriate court or magistrate for a TPRO. The hospital attorney shall prepare and file the application for such order. The hospital shall be authorized to retain custody of a child for a period not to exceed 24 hours from the time of request for such an order. 6.32 The parents shall be informed by the diagnostic team or the hospital attorney: a) of the time and place that the application for such order will be made; b) that they have a right to be present at the hearing on such application; c) that they have a right to be represented by counsel and that, if they cannot afford to retain counsel, the court will appoint counsel for them prior to the commencement of the hearing on the application for the TPRO. 6.33 In no event shall parental consent be accepted or a TPRO be issued for a period in excess of 48 hours from the time the child arrived at the CIMC. At the end of 48 hours, a further consent or an extension of, or the issuance of, a TPRO shall be obtained for an additional period not to exceed 48 hours. Such limitations shall apply only to those situations where either the child is hospitalized for the purposes of examination, evaluation and testing to determine if the injury of condition is non-accidental or for the purposes of providing medical care and treatment, with or without determination of the non-accidental nature of the injury or condition, and the parents/caretakers refuse to consent to such hospitalization.
7.1 Referral of Parent/. Caretaker for Voluntary Services	7.2 CIMC Diagnostic Team	7.3 Whether abuse is or is not suspected, the diagnostic team may refer the parent or family unit to community resources providing services appropriate to their perceived needs. This referral shall consist of: a) Informing the parents of the types of services available, their location, and how to obtain such services, and

Model System Chart II

Phase II: CIMC Intake to Petition—Continued

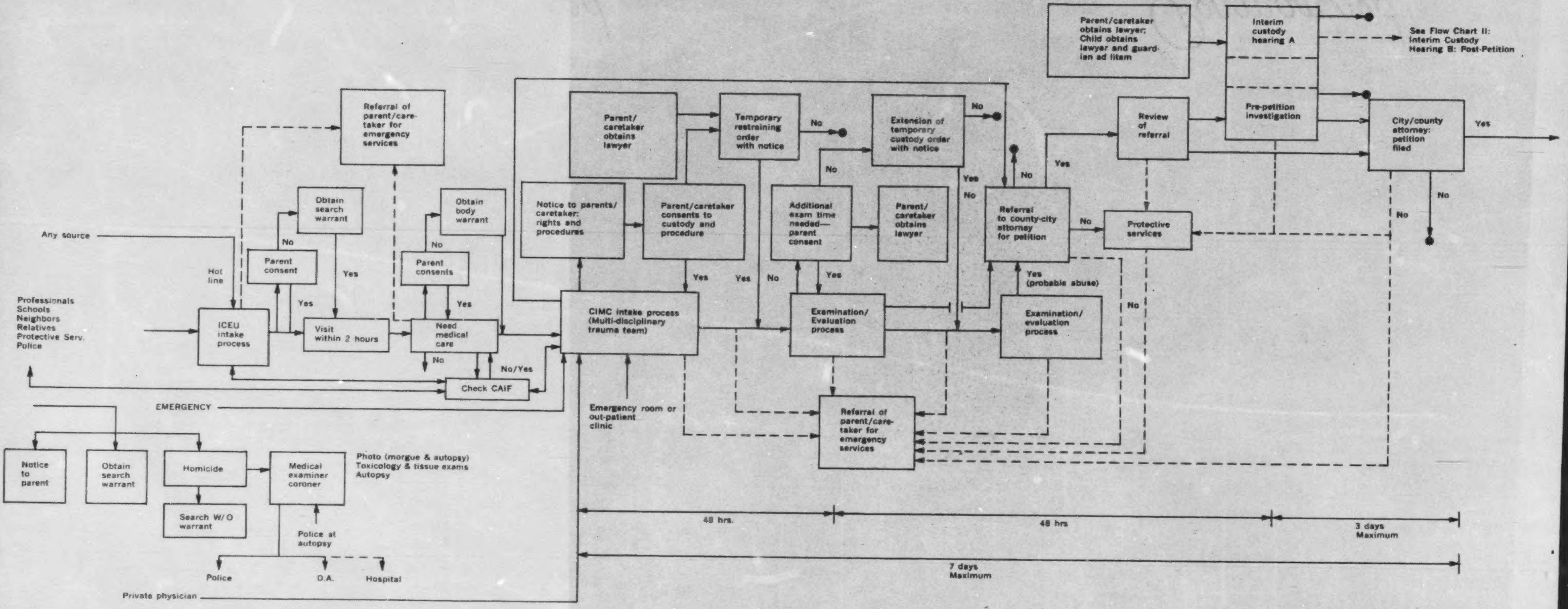
Decision	*Decision-Maker*	*Criteria/Guidelines*
7.1 (Cont'd.)	7.2 (Cont'd.)	7.3 (Cont'd.) b) Informing the parents that a diagnostic team member is available to assist them in obtaining desired services if the parents determine they need this assistance. Such referral shall be totally non-coercive, and unconditional. No other decisions in the model system shall be contingent upon the parents seeking or not seeking the suggested services.
8.1 Referral to County/City Attorney for Possible Petition	8.2 Diagnostic Team	8.3 An injured child case shall be referred to the county/city attorney whenever: a) The child's injury appears to be non-accidentally caused; or b) The child is severely injured (multiple fractures, head injuries, massive bruises, burns and/or severe hematomas, including old and new injuries) and either: (i) The parent/caretaker's explanation of the injury does not correspond with the nature of the injury, or (ii) Case evaluation suggests that the child is at risk in its current home environment; or c) The child is moderately injured and: (i) The parent/caretaker's explanation of the injury does not correspond with the nature of the injury, *and* (ii) Case evaluation suggests that the child is at risk, *or* *either* subsection (i) *or* (ii) above *and* (iii) The CAIF indicates previous adjudication for child abuse in the family *or* (v) The child has been in and out of foster care on a voluntary agreement; or d) The medical examination and evaluation process cannot be complete and conclusions as to the accidental or non-accidental nature of the injury cannot be made before the initial 96 hours (four day) period from the time of the referral of the child to the CIMC will expire.
9.1 Pre-petition Investigation	9.2 County/City Attorney/ Investigator	9.3 a) Upon referral of an injured child case, the county/city attorney shall cause an investigation to be made whenever: (i) The medical examination and case evaluation is inconclusive as to either the accidental or non-accidental nature of the injury or whether the child is at risk; or (ii) The medical examination and evaluation is not yet completed and the initial 96-hour (four day) period from the time of the referral of the child to the CIMC is about to, or has expired. b) The investigation shall be performed by the county/city attorney's investigative staff. The purpose of the investigation shall be to further determine the cause of the injury and whether the child is at risk in its current

Model System Chart II

Phase II: CIMC Intake to Petition—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
9.1 (Cont'd.)	9.2 (Cont'd.)	9.3 (Cont'd.) home environment. The investigation shall be completed and a report made as quickly as possible (and in no event shall such investigation extend longer than 72 hours or 3 days).
10.1 Filing of Petition	10.2 County/City Attorney	10.3 Whenever, on the basis of either the CIMC report and/or the pre-petition investigation report, there is no probable cause to believe a child's injury was the result of abuse, the county/city attorney may file a petition in the juvenile or family court.
10.11 No Petition Filed/ Referral to Protective Services	10.21 County/City Attorney	10.31 Whenever, on the basis of either the CIMC report and/or the pre-petition investigation report, there is not probabel cause to believe a child's injury was the result of abuse but there is probabel cause to believe the child is at risk in its current home environment (e.g., evidence of neglect, failure to thrive, etc.) the county/city attorney shall refer the case to the Protective Services Agency to be handled in accordance with child neglect laws.
10.12 No Petition Filed/ Referral for Voluntary Services	10.22 County/City Attorney	10.32 Whenever there is not probable cause to believe a child's injury was the result of abuse nor that the child is at risk in his current home environment, the county/city attorney may refer the parents to community resources appropriate to their perceived needs in accordance with the procedures outlined in section 7.3 above. Such a ref erral may also be made whenever the child's interests indicate that court action is inappropriate.

FLOW CHART I:—CHILD ABUSE—IDENTIFICATION TO PETITION


Any source
Hot line
Professionals
Schools
Neighbors
Relatives
Protective Serv.
Police
ICEU intake process
Parent consent
No
Yes
Obtain search warrant
Yes
Visit within 2 hours
Referral of parent/care-taker for emergency services
Parent consents
No
Yes
Obtain body warrant
Need medical care
No
No/Yes
Check CAIF
EMERGENCY
Notice to parent
Obtain search warrant
Homicide
Search W/O warrant
Medical examiner coroner
Photo (morgue & autopsy)
Toxicology & tissue exams
Autopsy
Police at autopsy
Police
D.A.
Hospital
Private physician
CIMC intake process (Multi-disciplinary trauma team)
Emergency room or out-patient clinic
Notice to parents/caretaker: rights and procedures
Parent/caretaker obtains lawyer
Parent/caretaker consents to custody and procedure
Yes
Temporary restraining order with notice
No
Yes
No
Additional exam time needed—parent consent
No
Yes
Parent/caretaker obtains lawyer
Extension of temporary custody order with notice
No
Yes
No
Examination/Evaluation process
Referral of parent/care-taker for emergency services
Referral to county-city attorney for petition
No
Yes
No
Yes (probable abuse)
Examination/evaluation process
No
Protective services
Review of referral
Parent/caretaker obtains lawyer; Child obtains lawyer and guard-ian ad litem
Interim custody hearing A
Pre-petition investigation
See Flow Chart II: Interim Custody Hearing B: Post-Petition
City/county attorney: petition filed
Yes
No
No
48 hrs.
48 hrs
3 days Maximum
7 days Maximum

PHASE I: Identification to CIMC intake

PHASE II: CIMC intake to petition

Note:
Interim Custody Hearing A:
Prior to filing of petiton

Model System Chart III
Phase III: Civil Adjudication Process

Decision	*Decision-Maker*	*Criteria/Guidelines*
1.1 Placement of child pending proceedings	1.2 Juvenile/Family Court	1.3 a) No later than 96 hours (4 days) from the time of a child's initial referral to the CIMC (or sooner if the parents do not consent to such emergency custody) upon petition by the county/city attorney, a hearing to determine the temporary custody of an injured child shall be commenced by the juvenile/family court whenever: (i) A petition has been or is about to be filed and the child has been determined to be at risk in its present home environment, or (ii) A pre-petition investigation has been or is about to be commenced under Phase II, section 9.3(a)(i) or (ii) above, or (iii) Additional time is required by the CIMC to complete its medical examination and evaluation, or (iv) Additional time is required to determine whether the child is at risk, or (v) In any case, whenever the CIMC team or the county/city attorney does not want to release the child to its parents. b) All parties shall be represented by counsel at such hearing and a guardian ad litem for the child shall also be appointed prior to or at the commencement of such hearing. c) If any of the parties require additional time to prepare for such hearing, the court may continue the hearing for a period not to exceed two (2) days and shall issue a temporary order concerning the custody of the child pending further hearing. d) In any order issued under 1.3(c), the court shall direct the child to be returned to its parents pending the further hearing unless the petitioner presents detailed facts under oath and the court finds that there is probable cause to believe that: (i) The child is a risk in its present home environment, or (ii) Continued removal is necessary to provide further medical care for the child's present injuries, or to protect the child from further injury until the cause of the present injuries can be determined. e) Upon the conclusion of the hearing in section 1.3(a) above, and in any case no later than the expiration of seven days from the time of a child's initial referral to the CIMC, the court shall order the child to be returned to the parents custody unless: (i) A petition has been filed and the petitioner presents detailed facts under oath and the court finds that there is probable cause to believe that the child is suffering from abuse and is at risk in its present home environment, and (ii) The court, in its order (called a preliminary order) specifies in writing the basis for the conclusion that the child is at risk in its present home environment and sets forth an explanation of which means, not involving the removal of the child had been contemplated, and why these means were inadequate for the child's protection.

Model System Chart III
Phase III: Civil Adjudication Process—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
2.1 Pre-adjudication Investigation	2.2 County/City Attorney and Investigative Staff	2.3 a) Whenever a petition is filed, an investigation may be commenced. The scope of the investigation may include: (i) The child's prior medical history and that of any siblings. (ii) Any prior records of the family unit in the CAIF. (iii) Locating and questioning possible witnesses. (iv) Home environment evaluation. (v) Collection and examination of physical evidence. (vi) Psychiatric and psychological evaluation of child or parents. b) Whenever psychiatric or psychological testing of either parents or child is desired, such testing shall occur only: (i) After consent from the parents or the child's guardian ad litem is obtained. (ii) Where consent is not given, upon court order after a hearing. c) Any pre-adjudication investigation report shall not be made available prior to the adjudication hearing. d) Discovery under the rules of civil procedure should apply and discovery should be liberally granted to all parties.
3.1 Plea Bargaining	3.2 Parent(s) and Counsel for Parents and City/County Attorney	3.3 a) The juvenile family court should not accept a plea admitting an allegation of a child abuse petition without determining that the plea is voluntary. In doing so, the court: (i) By inquiry of the attorney for the respondent and the county/city attorney, should determine whether the tendered plea is the result of a plea agreement, and if so, what agreement has been reached; and (ii) If the county/city attorney has agreed to seek dispositional concessions that must be approved by the court, should advise the respondent personally that those recommendations are not binding on the court; and (iii) Should then address the respondent personally and determine whether any other promises or inducements or any force or threats were used to obtain the plea; and (iv) Should then address the attorney for the child and the child's guardian ad litem to determine if they are aware of the plea agreement and if they both concur If either should not concur, the court should hear and consider these objections to such plea agreement. b) Whenever, prior to adjudication, a plea agreement has been reached which contemplates entry of a plea admitting an allegation of an abuse petition in the expectation that other allegations will be dismissed or not filed or that dispositional concessions will be recommended or granted, the family court judge should require disclosure of the agreement and the reasons therefore in advance of the time for tender of the plea. He should then indicate to the attorneys for all the parties whether he will concur in the proposed disposition if the

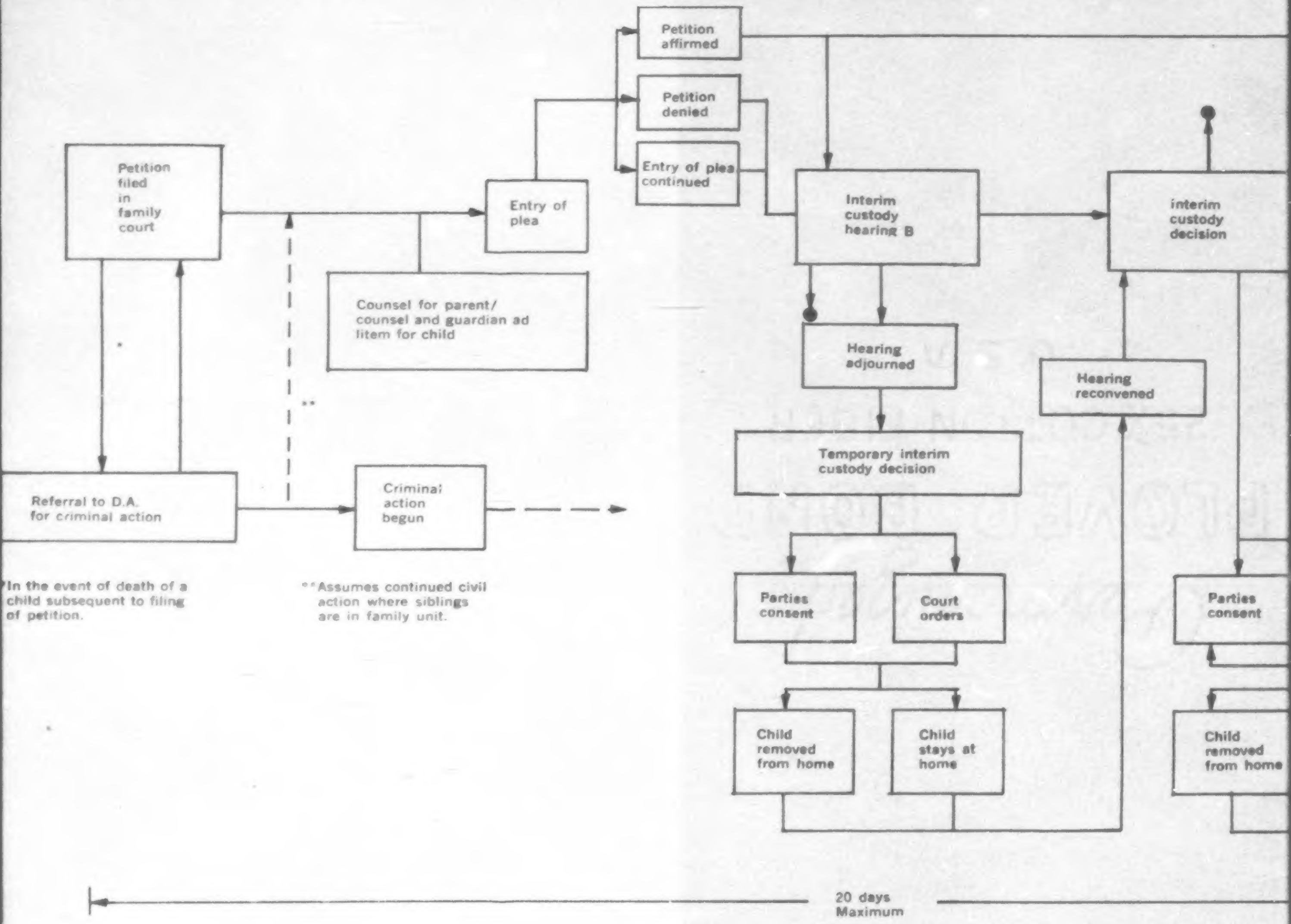
Model System Chart III
Phase III: Civil Adjudication Process—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
3.1 (Cont'd.)	**3.2 (Cont'd.)**	**3.3 (Cont'd.)** social information later received by him supports the proposed disposition. If the family court judge concurs, but later determines that the disposition should not include the terms contemplated by the plea agreement, h should so advise the respondent and then call upon him either affirm or withdraw his plea. c) When a plea admitting an allegation is tendered as a resu of a plea agreement, the family court judge should give the agreement due consideration, but not withstanding it existence he should reach an independent decision on whether to grant the concessions contemplated in the agreement. d) The family court should allow the respondent to withdra a plea admitting an allegation of the petiton whenever th respondent shows that: (i) He did not receive the concession contemplated by the plea agreement and the attorney for the government failed to seek or not to oppose those concessions as promised in the plea agreement; or (ii) He did not receive concessions contemplated in the plea agreement concurred in by the court, and he di not affirm his plea after being advised that the court no longer concurred and after being called upon to either affirm or withdraw the plea.
4.1 Adjudication	**4.2 Juvenile/Family Court Judge**	**4.3** a) An adjudication (fact-finding) hearing shall be held within 10 days following the filing of a petition. Upon the motio of any of the parties, the court may grant one continuanc not to exceed 10 days for good cause or upon the consen of all the parties. Further continuance may be granted only if all parties consent and the court is satisfied no harm will result from further delay. b) The court shall dismiss the petition upon the recommendation of the county/city attorney that the petition is without merit. The court shall dismiss the petition at the conclusion of the hearing if the petitioner fails to establish by a preponderance of the evidence the allegations of the petition. If the court finds the allegations in the petition proved by a preponderance of the evidence, or if all parties consent to such a finding, the court shall adjudge said child in need of care and protection and shall make an appropriat order for the care and custody of the child.
5.1 Disposition	**5.2 Juvenile/Family Court Judge**	**5.3** a) Procedure (i) Disposition order to be entered following hearing. (ii) Hearing to be within ten (10) days of adjudication. (iii) One 5-day continuance permitted on motion of any party and consent of all parties or for good cause shown.

Model System Chart III
Phase III: Civil Adjudication Process—Continued

Decision	*Decision-Maker*	*Criteria/Guidelines*
5.1 (Cont'd.)	5.2 (Cont'd)	5.3 (Cont'd.) (iv) Additional continuances limited as per 4.3(a) above. (v) Disposition report to be presented to counsel for parent and for child prior to hearing. Report not to be submitted to court until written response, if any, to report is made by parties. Response to be submitted simultaneously with report. b) Disposition Orders: The court shall enter order following the disposition hearing. The court may by such order: (i) Permit the child to remain in the custody of the parents or custodian and order a service plan be developed by protective services to assist the family. (ii) Transfer custody, temporarily, to any of the following only if there is no reasonable means available to protect the child while remaining in the custody of the respondent, or if the child is unwilling to remain in the custody of the respondent, or if the respondent is unwilling to maintain custody of the child: (a) Any relative or other person known to the child who is qualified to care for the child. (b) Any licensed private agency. (c) The child protective services agency. (iii) Under (b) (ii)(a)-(c) above the court shall also order and approve the development and implementation of the child to a service plan to facilitate the return the home. (iv) Any dispositional order shall remain in effect for any period determined by the court but not to exceed 6 months and shall be reviewed every 2 months if any party so requests. (v) Upon the expiration of the order, by consent of the parties or for good cause the order may be continued or modified and continued for a similar period not to exceed 6 months.

FLOW CHART II:—CHILD ABUSE—PETITION TO DISPOSITION


Petition affirmed
Petition denied
Entry of plea continued
Petition filed in family court
Entry of plea
Interim custody hearing B
interim custody decision
Counsel for parent/ counsel and guardian ad litem for child
*
**
Hearing adjourned
Hearing reconvened
Temporary interim custody decision
Referral to D.A. for criminal action
Criminal action begun
Parties consent
Court orders
Parties consent
Child removed from home
Child stays at home
Child removed from home
20 days Maximum

*In the event of death of a child subsequent to filing of petition.

**Assumes continued civil action where siblings are in family unit.

Phase III: Civil Adjudication Process

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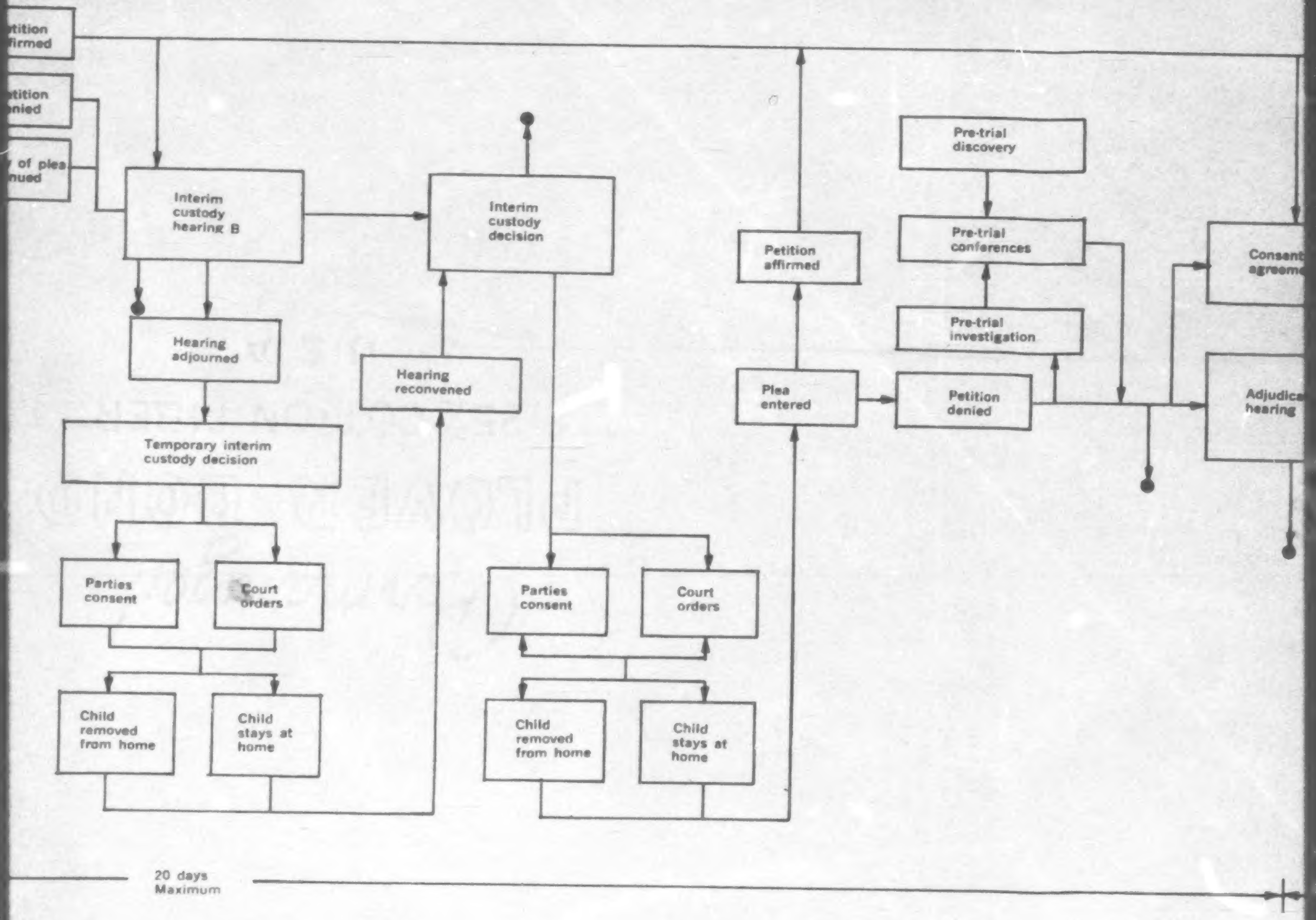
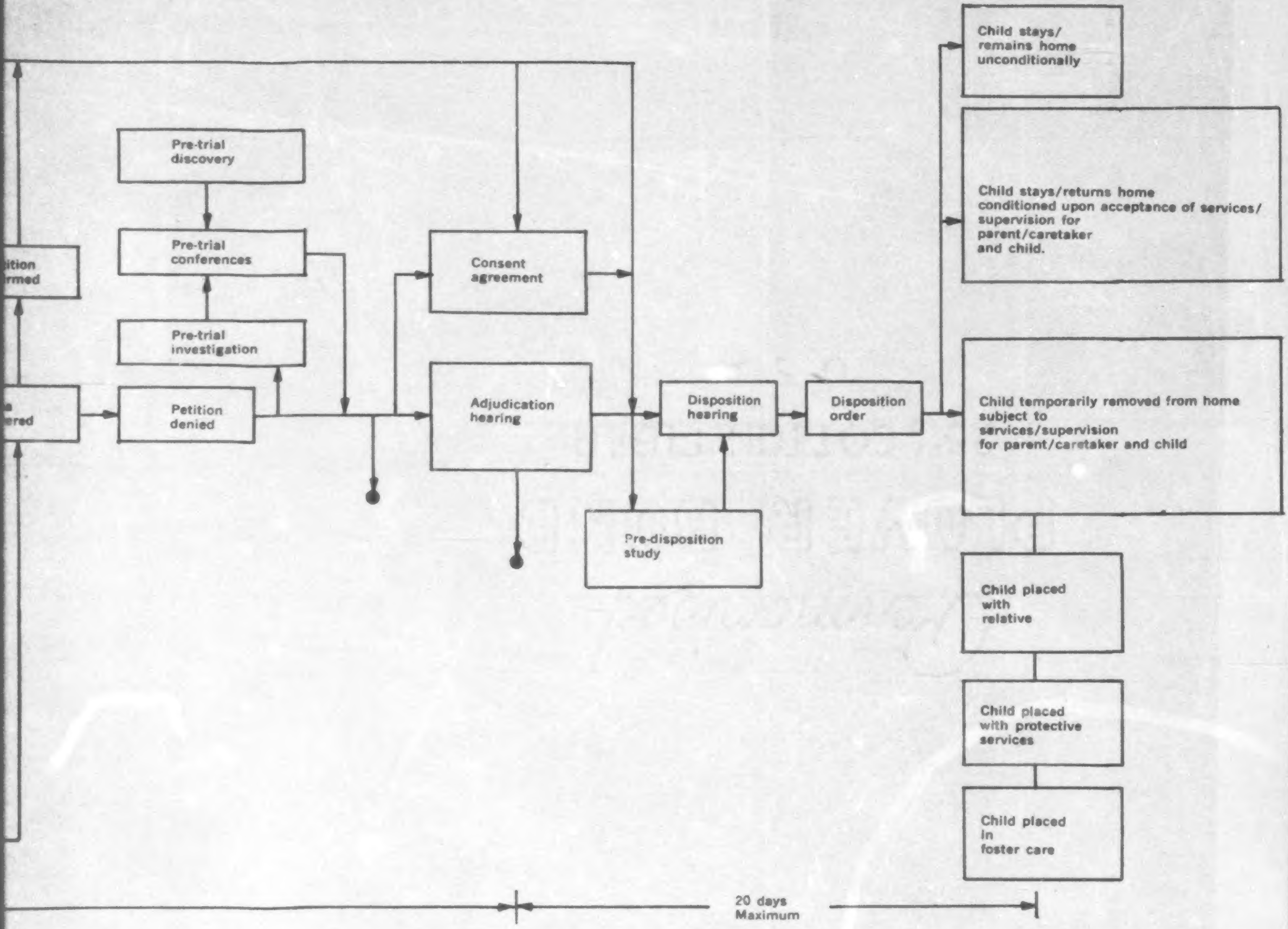
TION



tition
firmed
tition
nied
of plea
nued
Interim custody hearing B
Interim custody decision
Hearing adjourned
Hearing reconvened
Temporary interim custody decision
Parties consent
Court orders
Child removed from home
Child stays at home
Parties consent
Court orders
Child removed from home
Child stays at home
Petition affirmed
Plea entered
Pre-trial discovery
Pre-trial conferences
Pre-trial investigation
Petition denied
Consent agreeme
Adjudica hearing
20 days Maximum

Note: At any point in the
tion may be dismissed if
without merit.
The referral of the par
emergency or voluntary s
occur at any point.


ition
rmed
a
ered
Pre-trial discovery
Pre-trial conferences
Pre-trial investigation
Petition denied
Consent agreement
Adjudication hearing
Disposition hearing
Pre-disposition study
Disposition order
Child stays/ remains home unconditionally
Child stays/returns home conditioned upon acceptance of services/ supervision for parent/caretaker and child.
Child temporarily removed from home subject to services/supervision for parent/caretaker and child
Child placed with relative
Child placed with protective services
Child placed in foster care
20 days Maximum

Note: At any point in the process, the petition may be dismissed if determined to be without merit.
The referral of the parent/caretaker for emergency or voluntary services may also occur at any point.

CHAPTER X. QUESTIONS AND ANSWERS ON HANDLING CHILD ABUSE FOR JUSTICE SYSTEM PERSONNEL

In the model system, justice system personnel perform the same types of roles in handling child abuse as under the present system, as described in Chapter IX, but with some significant differences.

Law enforcement officers retain their emergency intervention role but, ideally, would be constrained in resorting to criminal procedures and would rely heavily on public health staff for preliminary examinations of the injured child in lieu of case investigation. Their investigative role would virtually be nil through the civil adjudication process.

The role of probation officers would change considerably in many communities under the model system wherein their primary responsibilities would emerge during post-disposition case coordination and monitoring in relation to the court ordered dispositional plan.

City or county attorneys would assume a different and more important role in handling child abuse cases. They would make the decision to file and otherwise handle all aspects of the petitioner's responsibilities in all civil adjudication processes, which is the primary judicial arena for handling child abuse cases under the model system.

Prosecutors of course would retain their discretionary authority to handle child abuse cases in criminal court under various criminal laws, from assault and battery to homicide. However, under the model system we have attempted to design a viable alternative of the criminal legal track for almost all types of child abuse. Child abuse is a very different charge to support with evidence in criminal court. Notwithstanding the existence of evidence that might support a conviction in child abuse cases, there are enough serious moral, professional, and social questions about criminal prosecution for most child abuse cases that the development of workable alternatives needs the support of prosecutors.

Judges in juvenile or family courts, are expected to fulfill a much more important role in the model system by presiding over an exacting civil court process incorporating full due process safeguards. The juvenile or family court envisioned in the model system is a court where the rule of law is vital, lawyer judges are essential, and retaining the child within a stabilized and secure home environment is the paramount goal.

In this section of the Prescriptive Package, we attempt to translate the strategic, operational, and legal aspects of the model system into sets of questions which justice system officials might ask as they read this volume and, afterwards, as they relate its content to their legal and professional responsibilities.

The answers to these questions are intended to summarize, generalize, and highlight the detailed discussion in Parts 1 and 2, and especially Part 3, Chapters VIII and IX pertaining to decision-making in the model system. Whereas Chapter IX of Part III organizes the guidelines for decision-making in terms of the *sequence of decisions* in the model system, this chapter is organized around the *principal decision-makers*. Just as Chapter IX closely related to Chapter VIII, Chapter X complements Chapter IX. For a much more extensive set of questions (and issues) relating to child abuse handling, the reader should refer to Appendix II. These questions (and issues) are explicitly or implicitly answered in Chapters IV and V of Part II.

A. Model System Questions and Answers

1. Law Enforcement

Q. *At what point do law enforcement personnel become involved in child abuse cases?*

A. In the course of performing normal police duties, when an injured child is encountered. In the event of an emergency report, the police may be the first public agency to intervene with the family in crisis. They may also be called into a case by the ICEU, if hostility from the parents is anticipated or if emergency removal of the child to the CIMC hospital is necessary.

Q. *What is the role of law enforcement personnel at this point?*

A. Using the least intrusive intervention necessary to protect the safety and well-being of the child, to determine whether the ICEU should be called upon to perform an initial examination of the child; to provide protection to ICEU personnel if parents appear hostile; and, if the child's immediate condition involves a medical emergency, to transport the child directly to the CIMC.

Q. *What legal authority do law enforcement personnel exert in performing these roles?*

A. To enter a home with consent of the residents, with a warrant, or without consent if there is probable cause to believe that the life or safety of a citizen is endangered, or that a crime has been committed; to examine a child who may have been injured, with the consent of the parent/caretaker or through use of a body warrant; to perform emergency removal of a child to a hospital to obtain medical treatment if the life or safety of the child presents a medical emergency.

Q. *What are the major responsibilities of law enforcement personnel in child abuse handling?*

A. To respond to emergency situations immediately and take action to protect the life and safety of citizens where endangered; to contact the ICEU where (non-emergency) injury to a child has occurred; to transport children to the CIMC in emergency situations; to exercise restraint in each of these instances so as to provide the least disruptive intervention necessary to protect the life and safety of the child.

2. Counsel for Local Jurisdiction

Q. *At what point do counsel for the local jurisdiction become involved in child abuse cases?*

A. When the child with an injury of suspicious origin is referred by the CIMC.

Q. *What is the role of the counsel at that point?*

A. To make a determination, based on review of the information presented by the CIMC or gathered during a separate pre-petition investigation, of whether there is probable cause to support a petition and of whether a civil court process is the appropriate means to handle the case.

Q. *What is the legal authority exerted by the local attorney?*

A. That of presenting petitions for emergency temporary protective custody; filing a civil petition in family or juvenile court for determination of risk to an injured child; and of conducting an investigation sufficient to develop a case for civil court, representing the locality in the proceedings; and developing dispositional alternatives.

Q. *What are the major responsibilities of the local attorney?*

A. To review cases referred by the CIMC (or any other source) for petition to civil court; to perform information gathering and investigation adequate for preparation of a civil court case; to explore dispositional alternatives; and to divert appropriate cases from the civil process by non-coercive referrals of families for voluntary services.

3. Prosecutors

Q. *At what point do prosecutors become involved in child abuse cases?*

A. Although the model system focuses on a civil process for justice system handling of inflicted injury to children by parents and caretakers, it is recognized that, under existing criminal procedures, death of a child caused by suspicious circumstances, or unexplained deaths, should be referred to the prosecutor by the police, the coroner, medical-examiner by any physician, medical facility or individual. Further it should be noted that the prosecutor has the discretion to commence a criminal court proceeding against any individual involved in child abuse where he is convinced there is sufficient admissible evidence based on a probable cause standard and that criminal prosecution would serve a socially desirable purpose.

Q. *What is the role and responsibilities of the prosecutor in child abuse cases?*

A. To fully investigate the circumstances surrounding the death of a child; to consider the legal, evidentiary, constitutional, and social issues raised by the facts; to determine the need for and adequacy of all evidence, documents, witnesses; to determine the charges appropriate under the facts and other considerations in the case; and to assess the potential value of dispositional alternatives for the specific cases.

4. Probation Officers

Q. *At what point do probation officers first become involved in child abuse cases?*

A. Not until the post-dispositional stage.

Q. *What is a probation officer's typical role at that point?*

A. The disposition plan ordered by the court may involve services or treatment from several agencies, e.g., the CIMC, public health, mental health, protective services, *et al.* The specific type and timing of "soft" and "hard" services will evolve from case management planning and monitoring, frequently performed by protective services. When service delivery bogs down, in terms of the court's disposition plan, the reasons for this situation, e.g., inter-agency communications problems, should be reflected in the regular formal and informal reports to the court. Probation should actively assist in remedying these problems to ensure continuity of service. When, for example, placements seriously falter or fail, probation should be made aware of the nature of the problem and should monitor the process of resolving the placement problem and its implications for the provisions of the dispositional plan, risk to the child, and the potential for reuniting the child with the natural family unit.

Q. *What legal authority do probation officers exert in carrying out the role?*

A. As the primary agents of the court, they may receive and evaluate periodic reports from primary (especially case management) agencies providing services to parents under court supervision; as necessary, recommend to the court changes in dispositional plans which seem appropriate from such review, including increase or decrease of agency activity, the addition of other services, perhaps a change in personnel assigned to work with a family, or possibly even termination of agency involvement, based on performance or other factors.

Q. *What are their major responsibilities in a case coordinating and monitoring role for the court?*

A. In addition to the functions described above, they prepare periodic written reports summarizing case progress in relation to the disposition plan, assessing adequacy of the plan and the effectiveness of its implementation for court review, and, at 6-month intervals from the dispositional order to termination of court involvement, apprise the court of progress and problems affecting achievement of the plan's objectives within the specified time-frames.

5. Judges

Q. *At what point do judges become involved in child abuse cases?*

A. At the first protective custody hearing (TPRO, TICO, or ICO), or when an abuse petition is filed.

Q. *What is the role of the judge at that point?*

A. Initially, to determine whether it is necessary to place custody of a child, for stated limited periods of time, in the custody of persons other than their parents, or in the custody of the parents with limitations or supervision. Subsequently, to conduct the civil hearing process. Generally, to authorize the least intrusive intervention necessary to protect the safety and well-being of the child.

Q. *What legal authority does the judge exert in carrying out this role?*

A. All the authority of the court to determine the facts, issue orders, and regulate the hearing process within the limits of Constitutional due process standards, case-law precedents, and statutory constraints.

Q. *What is the role of the judge during the pre-adjudication phase?*

A. To determine the appropriate placement of the child pending the court proceedings; to preside over the pre-trial discovery process, including resolving disputes between the parties over the scope of discovery; to preside over pre-trial conferences; to insure the pre-trial process moves along without delay.

Q. *What is the role of the judge during the adjudication hearing?*

A. To preside over the course and conduct of the proceedings as in any other civil trial.

Q. *What is the role of the judge in the disposition phase?*

A. To preside generally over the pre-disposition phase and hearing. To weigh the facts and testimony offered at the hearing concerning disposition plans, and to determine the least intrusive disposition that minimizes further risk to the child while maintaining or leading to the re-establishment of the family unit.

Q. *What is the role of the judge during the post-dispositional period?*

A. To conduct further hearings when appropriate or requested by the parties to review part or all of the disposition order and to make changes in the initial order when appropriate.

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PRESCRIPTIVE PACKAGE: "CHILD ABUSE INTERVENTION"

To help LEAA better evaluate the usefulness of Prescriptive Packages, the reader is requested to answer and return the following questions.

1. What is your general reaction to this Prescriptive Package?
   ☐ Excellent ☐ Above Average ☐ Average ☐ Poor ☐ Useless

2. Does this package represent best available knowledge and experience?
   ☐ No better single document available
   ☐ Excellent, but some changes required (please comment)
   ☐ Satisfactory, but changes required (please comment)
   ☐ Does not represent best knowledge or experience (please comment)

3. To what extent do you see the package as being useful in terms of: (check one box on each line)

	Highly Useful	Of Some Use	Not Useful
Modifying existing projects	☐	☐	☐
Training personnel	☐	☐	☐
Adminstering on-going projects	☐	☐	☐
Providing new or important information	☐	☐	☐
Developing or implementing new projects	☐	☐	☐

4. To what specific use, if any, have you put or do you plan to put this particular package?
   ☐ Modifying existing projects
   ☐ Administering on-going projects
   ☐ Others:
   ☐ Training personnel
   ☐ Developing or implementing new projects

5. In what ways, if any, could the package be improved: (please specify), e.g. structure/organization; content/coverage; objectivity; writing style; other)

6. Do you feel that further training or technical assistance is needed and desired on this topic? If so, please specify needs.

7. In what other specific areas of the criminal justice system do you think a Prescriptive Package is most needed?

8. How did this package come to your attention? (check one or more)
   ☐ LEAA mailing of package
   ☐ Contact with LEAA staff
   ☐ LEAA Newsletter
   ☐ Other (please specify)
   ☐ Your organization's library
   ☐ National Criminal Justice Reference Service

9. Check ONE item below which best describes your affiliation with law enforcement or criminal justice. If the item checked has an asterisk (*), please also check the related level, i.e.

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- ☐ Commercial/Industrial Firm
- ☐ Citizen Group
- ☐ Police *
- ☐ Court *
- ☐ Correctional Agency *
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